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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

September 2023

Cycle 6
Medical Inspection Report

California Health Care Facility

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Contents

Illustrations

Tables

Figures

Photographs

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated people[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

[1] In this report, we use the terms *patient* and *patients* to refer to *incarcerated people*.

[2] The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

[3] In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

[4] The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

[5] If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and second, we consider whether institutional medical processes lead to identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

As we did during Cycle 5, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of California Health Care Facility (CHCF), the institution had not been delegated back to the department by the receiver.

We completed our sixth inspection of CHCF, and this report presents our assessment of the health care provided at this institution during the inspection period from December 2021 to May 2022.[6] The data obtained for CHCF, and the on-site inspections occurred during the COVID-19 pandemic.[7]

California Health Care Facility is a 54-building complex located in South Stockton. The facility offers housing and treatment for 2,951 incarcerated person-patients, which are provided by a professional health care staff of 2,500. CHCF provides medical care and mental health treatment to incarcerated people who have the most severe and long-term needs. The 1.4 million square foot facility is certified to provide intermediate level care and to complement less acute treatment provided in other prisons operated by the department. This facility provides both outpatient and inpatient mental health services for patients with mental health disorders. The licensed psychiatric inpatient program at this facility is designed to provide more intensive treatment for patients who cannot function adequately or stabilize in an outpatient program. CHCF has a correctional treatment center (CTC) for inpatient services, an outpatient housing unit (OHU), a clinic for dialysis, and beds for mental health crisis treatment. CHCF has been designated an *intermediate* (as opposed to a *basic) care prison*; these institutions are predominately located in urban areas close to medical centers and specialty care providers who are likely to be used by a patient population with higher medical needs.

[6] Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency non- cardiopulmonary (CPR) reviews between September 2021 and June 2022, emergency CPR reviews between April 2021 and May 2022, death reviews between December 2020 and September 2021, and transfer reviews between April 2021 and May 2022.

[7] As of June 20, 2023, the department reports on its public tracker that 83% of its incarcerated population at CHCF is fully vaccinated while 86% of CHCF staff is fully vaccinated: http://www.cdcr.ca.gov/covid19/population-status-tracking/.

Summary

We completed the Cycle 6 inspection of CHCF in January 2023. OIG inspectors monitored the institution's delivery of medical care that occurred between December 2021 to May 2022.

The OIG rated the overall quality of health care at CHCF as ***inadequate***. We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. CHCF Summary Table

Ratings
Proficient *Adequate* *Inadequate*

Health Care Indicators	Cycle 6 Ratings: Case Review	Cycle 6 Ratings: Compliance	Cycle 6 Ratings: Overall	Change Since Cycle 5*
Access to Care	Adequate	Adequate	Adequate	↑
Diagnostic Services	Adequate	Inadequate	Inadequate	=
Emergency Services	Inadequate	N/A	Inadequate	↓
Health Information Management	Inadequate	Inadequate	Inadequate	=
Health Care Environment	N/A	Inadequate	Inadequate	=
Transfers	Adequate	Adequate	Adequate	↑
Medication Management	Inadequate	Inadequate	Inadequate	=
Prenatal and Postpartum Care	N/A	N/A	N/A	N/A
Preventive Services	N/A	Adequate	Adequate	↑
Nursing Performance	Inadequate	N/A	Inadequate	↓
Provider Performance	Inadequate	N/A	Inadequate	=
Reception Center	N/A	N/A	N/A	N/A
Specialized Medical Housing	Inadequate	Adequate	Inadequate	=
Specialty Services	Inadequate	Inadequate	Inadequate	=
Administrative Operations†	N/A	Inadequate	Inadequate	=

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Administrative Operations** is a secondary indicator and is not considered when rating the institution's overall medical quality.

Source: The Office of the Inspector General medical inspection results.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 416 patient records and 1,683 data points and used the data to answer 94 policy questions. In addition, we observed CHCF processes during an on-site inspection in August 2022. Table 2 below lists CHCF average scores from Cycles 4, 5, and 6.

Table 2. CHCF Policy Compliance Scores

Scoring Ranges

100%–85.0% | 84.9%–75.0% | 74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	89.0%	68.2%	80.3%
2	Diagnostic Services	62.2%	62.8%	51.7%
4	Health Information Management	78.2%	63.8%	74.3%
5	Health Care Environment	62.4%	69.5%	49.3%
6	Transfers	75.4%	46.3%	84.3%
7	Medication Management	69.9%	51.9%	50.8%
8	Prenatal and Postpartum Care	*N/A*	*N/A*	*N/A*
9	Preventive Services	83.0%	69.7%	78.2%
12	Reception Center	*N/A*	*N/A*	*N/A*
13	Specialized Medical Housing	74.4%	85.0%	79.7%
14	Specialty Services	69.8%	65.7%	62.2%
15	Administrative Operations	57.2%*	71.1%	72.7%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

Source: The Office of the Inspector General medical inspection results.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 66 cases, which contained 2,502 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in January 2023 to verify their initial findings. The OIG physicians rated the quality of care for 30 comprehensive case reviews. Of these 30 cases, our physicians rated 21 ***adequate*** and nine ***inadequate***. Our physicians found no adverse deficiencies during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[8] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our OIG clinicians acknowledged institutional structures that catch and resolve mistakes which may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in the CHCF Summary Table.

In July 2022, the Health Care Services Master Registry showed that CHCF had a total population of 2,232. A breakdown of the medical risk level of the CHCF population as determined by the department is set forth in Table 3 below.[9]

Table 3. CHCF Master Registry Data as of July 2022

Medical Risk Level	Number of Patients	Percentage*
High 1	1,187	53.2%
High 2	408	18.3%
Medium	462	20.7%
Low	175	7.8%
Total	**2,232**	**100.0%**

* Percentages may not total 100% due to rounding.

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 7-18-22.

[8] The indicators for **Reception Center** and **Prenatal and Postpartum Care** did not apply to CHCF.

[9] For a definition of *medical risk*, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, CHCF had three vacant executive leadership positions, one primary care provider vacancy, 44.7 nursing supervisor vacancies, and 370.1 nursing staff vacancies.

Table 4. CHCF Health Care Staffing Resources as of July 2022

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	10.0	36.0	155.7	1,433.3	1,635.0
Filled by Civil Service	9.0	36.0	111.0	1,063.2	1,219.2
Vacant	3.0	1.0	44.7	370.1	418.8
Percentage Filled by Civil Service	90.0%	100%	71.3%	74.2%	74.6%
Filled by Telemedicine	0	0	0	0	0
Percentage Filled by Telemedicine	0	0	0	0	0
Filled by Registry	0	2.0	0	163.0	165.0
Percentage Filled by Registry	0	5.6%	0	11.4%	10.1%
Total Filled Positions	9.0	38.0	111.0	1,226.2	1,384.2
Total Percentage Filled	**90.0%**	**105.6%**	**71.3%**	**85.6%**	**84.7%**
Appointments in Last 12 Months	4.0	2.0	43.0	324.0	373.0
Redirected Staff	0	0	0	5.0	5.0
Staff on Extended Leave‡	0	1.0	0	90.0	91.0
Adjusted Total: Filled Positions	**9.0**	**37.0**	**111.0**	**1,131.2**	**1,288.2**
Adjusted Total: Percentage Filled	**90.0%**	**102.8%**	**71.3%**	**78.9%**	**78.8%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 6 medical inspection preinspection questionnaire received on July 18, 2022, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency. An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[10] The OIG did not find any adverse events at CHCF during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CHCF. Of these 10 indicators, OIG clinicians rated four ***adequate*** and six ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 21 were ***adequate***, and nine were ***inadequate***. In the 2,502 events reviewed, there were 806 deficiencies, 168 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at CHCF:

- Patients had good access to providers and nurses.
- Staff completed most diagnostic tests timely.
- Staff retrieved hospital discharge reports, and providers endorsed these reports timely.
- Provider emergency care was very good.

Our clinicians found the following weaknesses at CHCF:

- Provision of new medication and chronic medication continuity were problematic.
- CTC and OHU nurses' assessments and interventions needed improvement, especially for patients needing emergency services.
- Providers' performance was lacking in several areas: endorsements of diagnostic and specialty reports, CTC and OHU documentation, and decision-making.

[10] For a further discussion of an adverse event, see Table A–1.

- Many specialty access appointments did not occur within requested time frames.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to CHCF. Of these 10 indicators, our compliance inspectors rated four ***adequate*** and six ***inadequate***. We tested policy compliance in **Health Care Environment**, **Preventive Services**, and **Administrative Operations** as these indicators do not have a case review component.

CHCF demonstrated a high rate of policy compliance in the following areas:

- Nursing staff at CHCF reviewed health care services request forms and conducted face-to-face encounters within required time frames. In addition, CHCF housing units contained adequate supplies of health care request forms.

- Patients with chronic care conditions and those returning from outside community hospitals saw their primary care providers within the specified time frames. Moreover, patients were referred timely to their providers upon arrival at the institution.

- The institution performed well in providing preventative services for their patients, such as influenza vaccination, annual testing for tuberculosis (TB), and colorectal cancer screenings.

CHCF demonstrated a low rate of policy compliance in the following areas:

- Health care staff did not consistently follow universal hand hygiene precautions during patient encounters.

- CHCF's medical warehouse had multiple medical supplies that were expired.

- Nursing staff did not regularly inspect emergency response bags and treatment carts.

- Patients did not always receive their chronic care medications within required time frames. There was poor medication continuity for patients returning from hospitalizations, for patients admitted to specialized medical housing, and for patients laying over at CHCF.

- Providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.

- CHCF often did not ensure specialty service reports were received timely. Furthermore, providers often did not review these reports within required time frames.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report,* the OIG obtained California Medi-Cal and Kaiser Medi-Cal HEDIS scores for one diabetic measure to use in conducting our analysis, and we present that here for comparison.

HEDIS Results

We used population-based metrics in considering CHCF's performance to assess the macroscopic view of the institution's health care delivery. We list the applicable HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs—California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)— CHCF rate of performance was very good in the one diabetic measure that has statewide comparative data: poor HbA1c control.

Immunizations

Statewide comparative data were also not available for immunization measures; however, we include these data for informational purposes. CHCF had a 76 percent influenza immunization rate for adults 18 to 64 years old and an 88 percent influenza immunization rate for adults 65 years of age and older.[11] The pneumococcal vaccine rate was 90 percent.[12]

Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CHCF had an 86 percent colorectal cancer screening rate.

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[11] The HEDIS sampling methodology requires a minimum sample of 10 patients to have a reportable result.

[12] The pneumococcal vaccines administered are the 13, 15, and 20 valent pneumococcal vaccines (PCV13, PCV 15, and PCV 20), or 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was currently housed during the inspection period.

Table 5. CHCF Results Compared With State HEDIS Scores

HEDIS Measure	CHCF Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	98%	–	–	–
Poor HbA1c Control (>9.0%)‡,§	**3%**	42%	34%	23%
HbA1c Control (<8.0%)‡	85%	–	–	–
Blood Pressure Control (<140/90)‡	86%	–	–	–
Eye Examinations	83%	–	–	–
Influenza–Adults (18–64)	76%	–	–	–
Influenza–Adults (65+)	88%	–	–	–
Pneumococcal–Adults (65+)	90%	–	–	–
Colorectal Cancer Screening	86%	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in August 2022 by reviewing medical records from a sample of CHCF's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2020–June 30, 2021 (published April 2022); **https://www.dhcs.ca.gov/dataandstats/reports/Documents/EQRTechRpt-Vol1.pdf**.

‡ For this indicator, the entire applicable CHCF population was tested.

§ For this measure only, a lower score is better.

Source: Institution information provided by the California Department of Corrections and Rehabilitation. Health care plan data were obtained from the CCHCS Master Registry.

Recommendations

As a result of our assessment of CHCF's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should determine the root causes(s) of challenges in the timely provision of nurse-to-provider referral appointments and should ensure that specialty services follow-up appointments are completed within required time frames.

Diagnostic Services

- The department should consider developing strategies to ensure that providers create patient letters at the time of test endorsement and that patient letters contain all elements required per CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely collecting or receiving of STAT laboratory results and implement remedial measures as appropriate. Medical leadership should consider developing strategies to ensure STAT test results were acknowledged by providers or notified within required time frames.

- Medical leadership should determine the root cause(s) of challenges in receiving pathology reports timely and implement remedial measures as appropriate.

Emergency Services

- Leadership should ensure that all staff are reminded to activate the 9-1-1 system immediately for patients who need to be transported for a higher level of care.

- Nursing leadership should ensure that nurses who deliver emergency care perform complete assessments, provide appropriate interventions, and thoroughly document their actions, including accurate timelines.

- Nursing leadership should ensure supervising registered nurses (SRNs) complete thorough audits of emergent events in which patients transfer to higher level of care.

Health Information Management

- CCHCS leadership should consider developing and implementing an automatic tracking system in the EHRS to monitor receipt, scanning, and provider endorsement of specialty and diagnostic reports.

- Medical leadership should determine the root cause of challenges to properly scan, label, and include medical records in the correct patients' files, instituting corrective action as needed.

Health Care Environment

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, located outside the clinics, store medical supplies adequately.

- Executive leadership should ensure that random spot checks are performed to ensure clinics, medical storage rooms, and restrooms have been cleaned.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried and sealed.

Transfers

- Nursing leadership should remind and train receiving and release (R&R) nurses to completely answer and address required initial health screening questions.

Medication Management

- Medical and nursing leadership should ensure that medications for new prescriptions, chronic care, hospital discharge, and en-route patients are administered timely and without interruption; leadership should implement remedial training as appropriate.

- Nursing leadership should ensure that nurses document in the patient's medical administration record the reason for the patient's refusal.

Preventive Services

- Nursing leadership should consider developing and implementing measures to ensure that nursing staff monitor patients who are prescribed TB medications according to CCHCS policy.

- Medical leadership should determine the causes for challenges to the timely provision of immunizations to chronic care patients.

Nursing Performance

- Nursing leadership should ensure that nurses evaluate patients with symptomatic complaints within one business day.

- Nursing leadership should ensure that nurses perform complete, thorough patient assessments and provide appropriate interventions.

Provider Performance

- Medical leadership should counsel providers to refrain from copying their previous progress notes without modifying the information to accurately reflect the plan and actions of the medical team.

- Medical leadership should evaluate concerns about personal safety in the OHU units and implement corrective measures.

Specialized Medical Housing

- Nursing leadership should ensure that CTC and OHU nursing staff perform thorough patient assessments, recognize changes in clinical status, and intervene timely and appropriately for patients with urgent and nonurgent medical conditions.

- Nursing leadership should continue performing nursing performance audits for objective assessments and documentation at regular intervals.

- The institution should consider developing and implementing measures to ensure that staff timely make medications available, administer to patients housed in specialized medical housing, and document in the medication administration record (MAR) summaries as described in CCHCS policy and procedures.

Specialty Services

- Medical leadership should ascertain causative factors related to the untimely provision or scheduling of patients' specialty service appointments and implement remedial measures as appropriate.

- Medical leadership should determine the root cause of challenges in patient notification of denials within required time frames and implement remedial measures as appropriate. Specifically, medical leadership should consider provider follow-up time frames of fewer than 30 days to discuss high-priority denials with patients. This may ensure that the rereferral process will be expedited.

Access to Care

In this indicator, OIG inspectors evaluated the institution's performance in providing patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick calls, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(80.3%)

Results Overview

Compared with Cycle 5, CHCF improved overall and provided good access to care. Both case review and compliance testing found CHCF generally performed well in provider and nursing access. However, specialty services access needed improvement. After reviewing all aspects of access to care, the OIG rated this indicator ***adequate***.

Case Review and Compliance Testing Results

OIG clinicians reviewed 293 outpatient provider, nursing, urgent or emergent care, specialty, and hospital events that required CHCF to generate appointments. We identified 25 deficiencies relating to this indicator, 12 of which were significant.

Access to Care Providers

CHCF's performance was good for provider-ordered follow-up appointments. Compliance testing found that chronic care face-to-face follow-up appointments occurred 88.0 percent of the time; however, nursing referrals to provider appointments occurred less often at 65.0 percent of the time (MIT 1.001 and MIT 1.005). Case review clinicians reviewed six detailed outpatient cases and found no deficiencies in the scheduling of outpatient provider appointments.

Access to Specialized Medical Housing (SMH) Providers

In Cycle 6, CHCF has improved in specialized medical housing (SMH) provider access. Of the 381 SMH provider encounters reviewed, we identified seven provider access deficiencies, three of which were significant.[13]

Waivers extending the frequency of provider visits for the outpatient housing unit (OHU) had been available for Cycle 5, and, in Cycle 6, the California Department of Public Health (CDPH) extended CTC visit time frames as well. Requirements for licensed CTC beds meant that providers needed to see patients every three days; however, the CDPH waiver allowed medically stable CTC patients to be seen at up to 14-day intervals, depending on the length of their

[13] Deficiencies were cited in cases 5, 11, 17, and 22. Significant deficiencies were cited in cases 11 and 17.

stay. This allowed providers longer time intervals between patient care visits, improving access to providers. This is significant since most of CHCF's patient population resides in the SMH units.

Access to Clinic Nurses

CHCF performed well in access to nursing sick calls and provider-to-nurse referrals. Compliance testing found that patients' requests for services were reviewed the day received, and nursing face-to-face follow-up visits usually occurred within one business day (MIT 1.003, 100% and MIT 1.004, 92.1%). Our clinicians assessed nursing sick call requests in 29 cases and identified one deficiency related to clinic nurse access.[14]

Access to Specialty Services

CHCF performance was mixed in referrals to specialty services. Compliance testing determined the following had occurred:

- There was a poor completion rate of initial high-priority specialty appointments, but high-priority specialty follow-up appointments usually occurred timely (MIT 14.001, 40.0% and MIT 14.003, 83.3%);
- Initial medium-priority and routine-priority specialty appointments often occurred timely, but medium-priority and routine-priority specialty follow-up appointments did not (MIT 14.004, 73.3%, MIT 14.007, 86.7%, MIT 14.006, 66.7%, and MIT 14.009, 60.0%);
- CHCF did not provide timely specialty appointments for patients transferring in from another CDCR institution with preexisting specialty appointments (MIT 14.010, 25.0%).

Case review clinicians also found that many specialty appointments did not occur within requested time frames. This is discussed further in the **Specialty Services** indicator.

Follow-Up After Specialty Services

Compliance testing revealed that only 52.4 percent of specialty service follow-up appointments with providers occurred within the required time frame (MIT 1.008). Current CCHCS policy states that only high-priority specialty visits require follow-up appointment with their assigned primary care provider. Case reviewers examined cases that contained routine, medium, and high-priority specialty visits. We did not find any significant deficiencies related to provider access after specialty appointments.

Follow-Up After Hospitalization

Staff performed well in ensuring that providers saw patients after hospitalizations (MIT 1.007, 87.5%). Of 70 hospital events, case review did not

[14] A significant deficiency was identified in case 62.

identify any deficiencies. This is discussed further in the **Clinician On-Site Inspection** area below.

Follow-Up After Urgent or Emergent Care

Providers generally saw their patients following a standby emergency medical services (SEMS) event when requested. At CHCF, the SEMS area is similar to the triage and treatment area (TTA) at other institutions. OIG clinicians reviewed four SEMS events that required provider follow-up appointments and identified no delays.

Follow-Up After Transferring Into CHCF

Primary care access for recent transfer-in patients was very good. Compliance testing showed access to intake appointments for newly arrived patients occurred within specified guidelines (MIT 1.002, 88.0%). OIG clinicians reviewed five transfer cases and found no access deficiencies.

Clinician On-Site Inspection

Our case review clinicians spoke with CHCF's executive leadership, medical and nursing leadership, providers, nurses, and schedulers about CHCF's access to care.

At the time of our inspection, CHCF had five main clinics: Facilities A, B, C, D, and E. Facilities A and B housed primarily mental health patients and had one provider. Facility C, an OHU with low-acuity patient care, has five clinics. Facility D encompasses the correctional treatment center (CTC) inpatient unit, memory care, and palliative care, and it has six clinics. Facilities C and D each had two housing units. Facility E is an OHU. Each of the three housing units had two providers that acted as team members providing backup coverage. During the day, all patients returning from the hospital and off-site specialty visits were first seen in the SEMS by the on-site provider. This may have accounted for improved posthospitalization access to providers.

CHCF also had on-site non-CCHCS specialty providers, off-site specialty providers, and telemedicine specialty providers. In addition, there were on-site CCHCS specialties such as registered dietetics, physical medicine and rehabilitation, and physical therapy. Kidney dialysis was performed on-site.

The inpatient housing units' CTC and OHU do not utilize the health care special requests forms.[15] Access for a large proportion of CHCF patient population; therefore, is not monitored through the 7362 process. Patients in the CTC and the OHU obtain care by speaking to medical staff. The scheduling staff clarified that if a patient required a provider appointment for a hospital or a specialty follow-up, the staff entered a communication order containing the necessary details. The communication orders were reviewed daily by nursing unit management, and these orders were entered to a spreadsheet not connected to

[15] The CDCR 7362 form is the health care services request form, commonly referred to by the form number. Patients can submit this form to request medical care.

the EHRS. This spreadsheet was used to track specialized medical housing appointment requests and to develop daily patient lists for providers and nursing.

The provider worked a schedule of four 10-hour days each week. Each provider worked with another provider as partners. Each covered the other provider's clinic for urgent and emergent patient needs on the one day the partner was scheduled to be out of the clinic. Several providers commented that this work schedule was a positive benefit to them overall, but that they had large patient populations to cover on their partner's day out of the clinic and that the partner's message inboxes were not covered except for emergencies.

OIG clinicians attended morning huddles, which were well attended by the patient care team and staff. The huddles were well organized. Providers and nurses communicated patient care needs appropriately.

Compliance On-Site Inspection

Patients had access to health care services request forms in all six housing units inspected in A Yard (PWC) and E Yard (MIT 1.101, 100%).

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? (1.001) *	22	3	0	88.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	22	3	0	88.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	38	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	35	3	0	92.1%
Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? (1.005) *	13	7	18	65.0%
Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? (1.006) *	1	1	36	50.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	14	2	0	87.5%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	11	10	24	52.4%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	6	0	0	100%
				Overall percentage (MIT 1): **80.3%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	40	7	0	85.1%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	47	N/A
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	6	9	0	40.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	5	1	9	83.3%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	11	4	0	73.3%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	2	9	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	6	4	5	60.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should determine the root causes(s) of challenges in the timely provision of nurse-to-provider referral appointments and should ensure that specialty services follow-up appointments are completed within required time frames.

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's performance in timely completing radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's performance in timely completing and reviewing immediate (STAT) laboratory tests.

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
***Inadequate* (51.7%)**

Results Overview

As in Cycle 5, overall, CHCF performed poorly in diagnostic services. Compliance testing showed that radiology and routine laboratory testing were usually completed timely, but STAT laboratory test completion and result notification processes both needed improvement. Case review found that test completion was generally timely. Both compliance and case review found lapses in the management of health information in diagnostics, such as delays in provider endorsements of radiology studies, late pathology report retrievals, and incomplete patient notification test results letters. Taking all factors into consideration, we rated this indicator ***inadequate***.

Case Review and Compliance Testing Results

We reviewed 740 diagnostic events and found 188 deficiencies, 14 of which were significant. Of these 188 deficiencies, we found 16 related to test completion, and 166 pertained to health information management (HIM).[16]

Test Completion

Compliance performance was mixed. Radiology and laboratory services were generally completed timely (MIT 2.001, 80.0% and MIT 2.004, 80.0%). However, timely STAT laboratory test completion with results notification occurred at a low rate of 10.0 percent (MIT 2.007).

Case review clinicians found that most diagnostic tests were completed timely with few delays. Most of the deficiencies were minor as they were completed up to one day late.[17] However, the following are two examples of longer delays:

- In case 11, the provider ordered a blood test to be done the next day. However, the blood test was collected nine days later.

[16] Test completion deficiencies in diagnostics occurred in cases 2, 11, 19, 23, 26–28, 31, and 34. HIM deficiencies in diagnostics occurred in cases 1, 2, 3, 5, 11–27, 29–35, and 42. Significant diagnostic deficiencies occurred in cases 3, 17, 19, 22, 25, 26, 29, and 42.

[17] Delays occurred in diagnostic completion in cases 2, 11, 16, 19, 26–28, 31, and 34. A significant deficiency occurred in case 19.

- In case 19, the nurse ordered a point-of-care test for COVID-19 to be performed on a specific date. However, this test did not occur.

Health Information Management (HIM)

CHCF's management of diagnostic health information was poor. Compliance testing showed timely provider review of laboratory reports; however, provider review of radiology reports needed improvement (MIT 2.005, 90.0% and MIT 2.002, 70.0%). In addition, timely provider acknowledgement or nurse notification of STAT laboratory results occurred only 40.0 percent of the time. (MIT 2.008). Performance of pathology report retrieval and providers' communication of the pathology results letters to patients were low, but performance in providers' reviews of pathology reports was better (MIT 2.010, 50.0%, MIT 2.012, zero, and MIT 2.011, 80.0%).

OIG clinicians reviewed 740 diagnostic events and identified 166 deficiencies related to the information management of diagnostic studies. We identified a pattern wherein pathology results were not always retrieved or scanned timely. Most HIM deficiencies were due to providers endorsing reports late, and incomplete or a lack of patient notification letters. We reviewed 24 STAT diagnostics studies and found four deficiencies related to HIM. Examples include the following:

- In case 17, the provider did not endorse a complete blood count test until one month after the results were available. The provider also did not endorse the direct antiglobulin test result until one month later.[18]

- In case 26, the lumbar spine X-ray was completed and available, but was not sent to the provider for review.

Clinician On-Site Inspection

We spoke with the supervisors of diagnostics and HIM about the deficiencies we identified during case reviews. They verbalized that the outside laboratory interfaces with the EHRS and that the laboratory results are automatically sent to the ordering provider. However, they also informed us that there was an error between Cerner and the radiology information system in the electronic provider notification. While we were told that this issue has been resolved, the staff stated there were no mechanisms in place to ensure providers endorsed diagnostic studies timely.

[18] The direct antiglobulin test is a blood test used to identify whether red blood cells have antibodies attached to the red blood cells' surface. This test can be used to help diagnose a type of anemia caused by the immune system.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	8	2	0	80.0%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	7	3	0	70.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	1	9	0	10.0%
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	2	8	0	20.0%
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	1	9	0	10.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frames? (2.008) *	4	6	0	40.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	1	0	90.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	5	5	0	50.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **51.7%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- The department should consider developing strategies to ensure that providers create patient letters at the time of test endorsement and that patient letters contain all elements required per CCHCS policy.

- Medical leadership should ascertain causative factors related to the untimely collecting or receiving of STAT laboratory results and implement remedial measures as appropriate. Medical leadership should consider developing strategies to ensure STAT test results were acknowledged by providers or notified within required time frames.

- Medical leadership should determine the root cause(s) of challenges in receiving pathology reports timely and implement remedial measures as appropriate.

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, Stand-by-Emergency Medical Services (SEMS), provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) performance in identifying problems with its emergency services. The OIG assessed the institution's emergency services mainly through case review.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

CHCF had a mixed performance in emergency services. SEMS nurses responded promptly and intervened as medically needed during medical emergencies. Providers generally evaluated patients appropriately. However, many emergency services occurred in the specialized medical housing units. Nurses who provided emergency services in specialized medical housing units often did not provide timely care including the use of appropriate emergent nursing protocols and prompt activation of 9-1-1. Documentation needed improvement. In addition, CHCF's quality review process did not identify its nurses' deficiencies. Subsequently, opportunities to provide staff with training and education were also missed. Therefore, we rated this indicator ***inadequate.***

Case Review Results

We reviewed 43 urgent and emergent events in the SEMS and specialized medical housing. We found 49 emergency care deficiencies, 19 of which were significant.[19]

Emergency Medical Response

We reviewed emergency medical responses in SEMS and specialized medical housing areas. We reviewed 16 events in which patients were transported to SEMS and were evaluated by SEMS nursing and provider staff. In addition, we reviewed 27 events in which patients were evaluated in specialized medical housing units and transferred to higher level of care.

Staff responded promptly to emergencies throughout the institution. They activated institutional alarms and initiated CPR appropriately. In the outpatient areas, staff activated emergency medical services (EMS), and notified SEMS staff in a timely manner. However, staff in the inpatient areas did not always activate 9-1-1 or provide appropriate nursing interventions timely. The following are examples of delays in patient care in specialized medical housing:

[19] Deficiencies occurred in cases 1–6, 8, 9, 11–14, 22, 26, 27, 29, 30, and 42. Significant deficiencies occurred in cases 1, 2, 5, 11, 13, 27, 29, 30, and 42.

- In case 1, the nurse did not immediately call 9-1-1 for the patient who arrived with symptoms of respiratory distress. Instead, the nurse contacted 9-1-1 later, 19 minutes after calling the provider and obtaining an order for transport to a higher level of care.

- In case 6, the OHU nurse assessed the patient after a fall and had suffered traumatic facial, back, and neck injuries. The nurse did not request 9-1-1 notification immediately. Instead, the patient was transferred to SEMS and evaluated by the provider, who ordered a transfer to a higher level of care 17 minutes later.

Cardiopulmonary Resuscitation Quality

Nursing staff mostly performed well in this area. Our clinicians reviewed four cases in which the patient required cardiopulmonary resuscitation (CPR).[20] Nursing and custody staff worked well together to provide care. They initiated CPR and frequently requested 9-1-1 without delay, except in case 8. Nursing staff responded timely, assessed the patient, and intervened appropriately. Nursing staff utilized the automated external defibrillator (AED) and provided oxygen to the patient. Our clinicians identified minor deficiencies in documentation. However, the deficiencies did not negatively impact the patient care that was provided. The following case is an example of an appropriate emergency response and interventions:

- In case 7, nursing staff found the patient unresponsive and not breathing. Nursing staff initiated CPR and called 9-1-1. SEMS nurses, respiratory staff, and provider staff promptly responded. The health care team used the AED and administered life-saving measures including emergency medication. EMS arrived and assumed care of the patient. Despite the timely and appropriate medical care provided by CHCF staff and EMS, the patient died.

Provider Performance

CHCF providers performed well in urgent and emergent situations and in after-hours care. They were available to nursing staff, made accurate diagnoses, and provided appropriate care. Usually documentation was completed, except in cases 13 and 30, in which the providers did not document progress notes.

Nursing Performance

CHCF nursing staff had a mixed performance during emergent medical events. SEMS nursing staff generally delivered good care during emergent events. They often provided appropriate and timely interventions, and communicated with the provider as required. However, medical inpatient nursing staff often performed incomplete assessments and delayed interventions as described below:

- In case 11, the CTC nurse assessed the patient who appeared drowsy, dizzy, and had an abnormally low blood pressure. The nurse did not

[20] The patients required CPR in cases 6–9.

provide emergent interventions such as obtaining a blood sugar check for a known diabetic patient. Instead, the nurse called the provider to evaluate the patient. Seven minutes later, the nurses activated a medical alarm for SEMS nursing staff to respond. Twelve minutes later, the SEMS nurse arrived at the unit, assessed the patient, and administered medication to increase the patient's blood sugar.

- In case 26, the patient complained of blood in his urine, chills, and vomiting. The nurse did not perform a thorough abdominal assessment including listening to bowel sounds.

- In case 30, the nurse documented that the patient, who had Huntington's disease, had an acute change in his condition with worsening neurological symptoms.[21] The patient was disoriented, drooling from the mouth, and unable to control his body movements. The nurse did not perform a thorough neurological assessment to identify the severity of neurological or motor symptoms, or timely notify the provider of the patient's urgent symptoms. Instead, the nurse documented that the patient would be discussed later in the clinic huddle. A few hours later, the patient was transported to a higher level of care for further care.

Nursing Documentation

SEMS nurses usually documented care provided for emergent events. However, our clinicians identified patterns of inconsistent nursing documentation that showed time lines of vital signs. These documentation deficiencies did not affect overall patient care.

Patient Care Environment

Nursing staff and providers observed patients in the inpatient housing units until they were transferred. Our clinicians identified a pattern in the delay of medically necessary care. Below are examples from three cases:

- In case 2, the staff evaluated a patient in the CTC with acute chest pain. The EKG showed abnormal findings. The EHRS was down for approximately 20 minutes. Instead of using downtime procedures, the medical staff waited until EHRS was available again. The provider did not provide verbal orders and nurses did not administer nitroglycerin, medication for chest pain, until the EHRS was available. This caused a delay in the treatment of the patient's acute chest pain.

- In case 29, the nurse and the provider evaluated a CTC patient with right-side upper extremity weakness and confusion. The nurses did

[21] Huntington's disease is a medical condition with progressive degeneration of nerve cells which affects a person's movement, function, thinking, and emotion.

not check the blood sugar timely nor complete the EKG (electrocardiogram) timely.

- In case 30, emergency care was provided for the patient with generalized weakness, dizziness, labored breathing, and an abnormally low oxygen saturation level. The nurse did not immediately contact 9-1-1 for the patient who was showing symptoms of respiratory distress. Instead, the nurse provided oxygen and contacted the provider. Fifteen minutes later, 9-1-1 was called after obtaining a provider's order.

Emergency Medical Response Review Committee

Our clinicians reviewed 12 emergency response events during the review period in which patients were assessed for emergent and urgent medical conditions and transferred to higher level of care.[22] EMRRC generally did not perform reviews within the required time frame (MIT 15.003, 16.7%). Analysis of the compliance data showed CHCF scored poorly due to incomplete completion of the EMRRC checklist, and the institution did not perform the initial review timely. Case reviewers also found that the chief medical executive (CME) and chief nurse executive (CNE) did not always sign the event checklist from the clinical review. In addition, when clinical reviews were conducted, the EMMRC did not identify opportunities for improvement for assessments, interventions, and documentation.

Clinician On-Site Inspection

At CHCF, SEMS is the designated area that was used for urgent and emergent care 24 hours a day. The area had four treatment rooms and a therapeutic module for overflow patient care. SEMS had one advanced cardiac life support (ACLS) cart and two emergency carts.

SEMS was staffed with three RNs and two LVNs on each shift. A provider was on duty in SEMS from 7 a.m. to 11 p.m. and on Fridays from 7 p.m. to Mondays at 7 a.m. During emergent events, the provider and an RN would respond. For ambulance transports to a higher level of care, nursing staff reported that nurses on the unit would call the ambulance for urgent transports. The SEMS nurse would follow up if the call was made and place a 9-1-1 call if needed.

For COVID-19 quarantine units, patients were seen in the units to assess the acuity level of the patient. Patients requiring urgent and emergent care were transferred to SEMS for further evaluation.

SEMS staff also assessed patients returning from off-site specialty appointments and hospitalizations. Prior to a patient's discharge from the hospital, the hospital would fax the patient's discharge packet to SEMS. A copy of the discharge packet would be given to the unit if the patient was going to an inpatient bed, a copy was scanned and sent to the hospital discharge HIM box for scanning, a copy was placed to upload to the CCHCS local share drive, and a copy of the discharge

[22] Emergency response events occurred in cases 1–9, 29, and 42.

summary was given to providers to review. The provider would see the patient, review recommendations, and enter appropriate orders.

Nursing staff also reported morale was low due to staffing issues, and many people were not adequately trained. CHCF nursing leadership reported registry staff generally received five days of CHCF training.

For emergencies, nursing leadership and supervisory staff reported that only the altered-level-of-consciousness nursing protocol could be used in SEMS. In the CTC, nurses notified the provider during business hours or the SEMS provider after hours for orders. In the OHU, our clinicians checked the medication tray in the urgent cart with the medications listed. However, nurses reported orders needed to be obtained prior to pulling medication for use.

SEMS nursing supervisors reported only Code 2 (urgent) and Code 3 (emergent) transfers to higher level of care required a clinical review.

Recommendations

- Leadership should ensure that all staff are reminded to activate the 9-1-1 system immediately for patients who need to be transported for a higher level of care.

- Nursing leadership should ensure that nurses who deliver emergency care perform complete assessments, provide appropriate interventions, and thoroughly document their actions, including accurate timelines.

- Nursing leadership should ensure SRNs complete thorough audits of emergent events in which patients transfer to a higher level of care.

Health Information Management

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital discharge reports) into the medical record in a timely manner. Our inspectors also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(74.3%)

Results Overview

Overall, CHCF did not perform well with HIM. Handling of hospital records and emergency documentation were the areas where CHCF performed well. However, other areas needed improvement. Managing of specialty and diagnostic reports needed improvement. Providers did not endorse specialty or diagnostic reports timely. Patient notification letters were either incomplete or not generated. Medical records were often not properly scanned, labeled, and included in the correct patient's files. After reviewing all aspects, the OIG rated this indicator ***inadequate***.

Case Review and Compliance Results

We reviewed 2,502 events and found 200 deficiencies related to HIM. Of these 200 deficiencies, 23 were significant.[23]

Hospital Discharge Reports

Staff performed very well with hospital discharge records. OIG clinicians reviewed 43 off-site emergency department and hospital visits. CHCF staff timely retrieved hospital records, scanned them into the medical record, and reviewed them properly. Case review found only one deficiency in case 14 in which the institution did not obtain a timely provider endorsement. Compliance test scores were also very good in the areas of timely retrieval, scanning, and endorsement of hospital discharge records (MIT 4.003, 93.8% and MIT 4.005, 87.5%)

Specialty Reports

Staff performed poorly in managing specialty reports. Compliance testing showed excellent retrieval of specialty reports, but poor rates of provider endorsement for all specialty reports: high-priority, medium-priority, and routine-priority (MIT 4.002, 90.0%, MIT 14.002, 53.9%, MIT 14.005, 46.7%, and MIT 14.008, 66.7%).

[23] Deficiencies occurred in cases 1–5, 11–27, 29–35, 42, and 62. Significant deficiencies were seen in cases 3–5, 12, 17, 19, 20, 22, 25, 26, 29, 32, 35, and 42.

Case review clinicians reviewed 303 specialty events and identified 26 deficiencies related to HIM.[24] Staff had some problems with late retrieval; this occurred three times, two of which were pathology reports associated with procedures. Fourteen of the 26 deficiencies resulted from either late endorsements or none having been provided. Examples of significant deficiencies include the following:

- In case 26, the provider endorsed the urology specialty report late by over one month.
- In case 32, the patient had a skin biopsy that showed basal cell carcinoma and squamous cell carcinoma, but the pathology report was retrieved almost one month late.
- In case 33, the patient had a consultation with the vascular surgeon. This report was not sent to or endorsed by the primary care provider.

We also discuss these findings further in the **Specialty Services** indicator.

Diagnostic Reports

CHCF needed improvement with its handling of diagnostic reports. Compliance testing found that STAT laboratory notifications often did not occur timely (MIT 2.008, 40.0%). Compliance testing showed that while the providers usually reviewed pathology results timely (MIT 2.011, 80.0%), they did not communicate the results to the patient timely (MIT 2.012, zero).

Case reviewers identified 69 deficiencies wherein diagnostics were endorsed late by providers and another 100 deficiencies wherein providers did not generate a complete patient notification letter. This was an area that could be improved.

- In case 22, the patient had blood work done to check for antibiotic levels to determine the proper dosage of the antibiotic. The provider did not endorse these results timely.

Please refer to the **Diagnostic Services** indicator for a detailed discussion about diagnostics.

Urgent and Emergent Records

OIG clinicians reviewed 21 emergent care events, and found that providers and nurses recorded these events well. The providers also documented their emergent care sufficiently, including off-site telephone encounters. We only identified two deficiencies in which providers did not record their interactions with the nurses when they were notified of the patients' change of condition. Refer to the **Emergency Services** indicator for additional information regarding emergent care documentation. The following is an example of a deficiency:

[24] Deficiencies occurred in cases 5, 11, 13, 16, 17, 20, 21, 26, 27, 29, 31–33, and 35.

- In case 13, the patient with cancer fell, and the nurse notified the provider-on-call. An EKG was ordered, and the patient was transported to a higher level of care. The provider did not document the decision-making rationale for this patient's care.

Scanning Performance

Scanning performance was mixed at CHCF. Compliance testing showed that medical records were not properly scanned, labeled, and included in the correct patient's file (MIT 4.004, zero). Case review found 11 deficiencies with documents that were incorrectly filed, dated, or scanned. The following are examples:

- In case 5, the nursing rounding log was scanned into the EHRS and mislabeled as a refusal of patient care.

- In case 18, refusal of care forms from other patients were misfiled in this patient's chart.

- In case 27, the nurse documented that a refusal form was filled out, but it was not scanned into the EHRS.

- In case 31, the patient's polyp pathology report was not scanned into the EHRS.

Clinician On-Site Inspection

We discussed HIM processes with HIM supervisors, providers, and nurses. The HIM supervisor described the process of retrieving documents from on-site and off-site diagnostic and specialty reports, which were automatically routed to providers for review. The supervisor discussed that once that occurs, the providers were responsible for endorsing the reports.

The HIM department was responsible for endorsement of off-site reports, but supervisors reported no automated tracking system currently existed to ensure endorsements occurred. Staff must manually enter the chart and access the file electronically to observe whether the specialty report was endorsed or not. They did not have the staff to do this effectively.

HIM supervisors reported they had staff shortages during the review period due to long-term staff absences and vacancies. Five of the six office assistant positions were vacant. Management stated that there was difficulty finding applicants for their available positions, but was not sure why.

HIM supervisors stated that they did not scan radiology reports. Most reports that they received were forwarded to diagnostic services for scanning and filing. There were exceptions such as some cardiac studies, which HIM staff scanned directly into the patient's electronic health record. HIM supervisors also advised there was no way to monitor and track whether off-site reports were received and scanned into the EHRS. They used a manual log to track whether a document had been received.

When we discussed missing and misfiled documents, we were told that incorrect training was partially responsible. Staff involved in the scanning or filing errors had been retrained.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	18	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	27	3	15	90.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	15	1	0	93.8%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	0	24	0	0
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	14	2	0	87.5%
Overall percentage (MIT 4): **74.3%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	9	1	0	90.0%
Laboratory: Did the provider acknowledge the STAT results, OR did nursing staff notify the provider within the required time frame? (2.008) *	4	6	0	40.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	5	5	0	50.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	8	2	0	80.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	6	2	53.9%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	7	8	0	46.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	10	5	0	66.7%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- CCHCS leadership should consider developing and implementing an automatic tracking system in the EHRS to monitor receipt, scanning, and provider endorsement of specialty and diagnostic reports.

- Medical leadership should determine the root cause of challenges to properly scan, label, and include medical records in the correct patients' files, instituting corrective action as needed.

Health Care Environment

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' performance in maintaining auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(49.3%)

Results Overview

Compliance Testing Results

In this cycle, the OIG inspectors determined that multiple aspects of CHCF's health care environment were in need of improvement: medical supply storage areas in- and outside the clinics contained expired medical supplies; emergency medical response bag (EMRB) logs were missing staff verification, inventory was not performed when seal tags were changed, or EMRBs contained expired medical supplies; several clinics did not meet the requirements for essential core medical equipment and supplies; and staff did not regularly sanitize their hands before and after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Outdoor Waiting Areas

The institution had no waiting areas that required patients to be outdoors.

Indoor Waiting Areas

We inspected indoor waiting areas. Health care and custody staff reported that existing waiting areas contained sufficient seating capacity (see Photo 1). Depending on the population, patients were either placed in the clinic waiting area or held in individual modules (see Photo 2, following page). During our inspection, we did not observe overcrowding or noncompliance with social distancing requirements in any of the clinics' indoor waiting areas.

Photo 1. Indoor waiting area (photographed on 8-10-22).

Photo 2. Individual modules (photographed on 8-10-22).

Clinic Environment

Of the 37 clinic locations, 34 applicable clinics were observed. In 32 of those 34 clinics, the clinic environments were sufficiently conducive to offering medical care. They provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 94.1%). In one clinic, however, the triage stations and recovery beds were near each other, prohibiting auditory privacy. In another clinic's common area, where examinations were not conducted, staff did not have sufficient space to work.

Of the 37 clinics we observed, 28 contained appropriate space, configuration, supplies, and equipment to allow their clinicians to perform proper clinical examinations (MIT 5.110, 75.7%). The remaining nine clinics had one or more of the following deficiencies: chairs (for staff and patients) and examination tables had torn vinyl covers; rooms were unnecessarily cluttered; nurses did not use the privacy curtains to ensure patient visual privacy while conducting clinical examination; clinics had unsecured confidential medical records; and examination room was near the patient's waiting area, prohibiting visual privacy while conducting clinical examination.

Clinic Supplies

Only one of the 37 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 2.7%). We found one or more of the following deficiencies in 36 clinics: expired medical supplies (see Photo 3, right); unorganized medical supplies; compromised sterile medical supply packaging; cleaning materials stored with medical supplies (see Photo 4, below); a medical supply was compromised, having been removed from its original packaging; and medical supplies were stored directly on the floor.

Photo 3. Expired medical supplies dated March and April 2022 (photographed on 8-10-22).

In addition, clinical staff reported difficulty obtaining medical supplies as many items had been placed on backorder per medical warehouse managers; there were unidentified or inaccurately labeled medical supplies; staff members' personal items and food were stored with medical supplies (see Photos 5 and 6, following page); designated staff personal storage drawer contained medical supplies; and staff members' personal bags had medical supplies stored that were intended to be utilized in the COVID-19 quarantine unit.

Photo 4. Cleaning materials stored with medical supplies (photographed on 8-9-22).

Photo 5. Medical supplies were found stored in the same area with employees' personal items (photographed on 8-9-22).

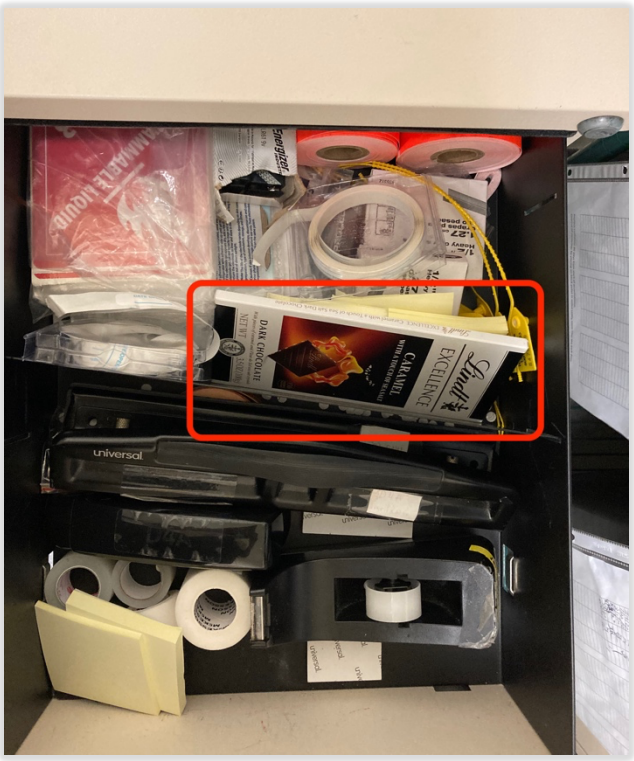

Photo 6. Medical supplies were found stored in the same area with employees' personal food (photographed on 8-10-22).

Of the 37 clinics, only seven met the requirements for essential core medical equipment and supplies (MIT 5.108, 18.9%). The remaining 30 clinics lacked medical supplies or had nonfunctional equipment. The missing items included a medication refrigerator and a biohazardous waste durable receptacle or bag. We found several nonfunctional otoscopes, ophthalmoscopes, and a pulse oximeter. Staff had not properly calibrated the following medical equipment: several automated vital signs machines, weight scales, and a nebulization unit. CHCF staff either did not perform daily performance checks of the automated external defibrillator (AED) or had not completed the defibrillator performance test log documentations within the last 30 days. In addition, daily glucometer quality control logs in several clinics were either inaccurate, incomplete, or had not been performed within the last 30 days.

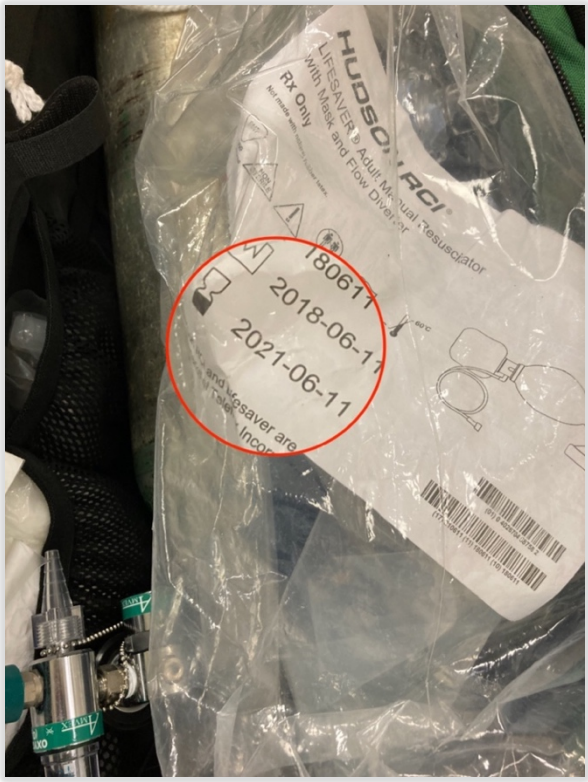

Photo 7. Expired medical supplies stored in the EMRB dated June 2021 (photographed on 8-9-22).

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only two of the 19 EMRBs and treatment carts passed our test (MIT 5.111, 10.5%). We found one or more of the following deficiencies with 17 EMRBs or treatment carts: staff failed to ensure the EMRBs' compartments were sealed and intact; staff had not inventoried the EMRBs when seal tags were replaced; expired medical supplies were stored in the EMRB (see Photo 7, left); carts did not meet the minimum inventory level nor was there documentation that reasonable substitutions were made; staff did not utilize the treatment cart inventory report (CDCR form 7547); staff did not utilize the treatment daily check log (CDCR form 7544); and expired medical supplies were stored in several treatment carts (see Photo 8, below).

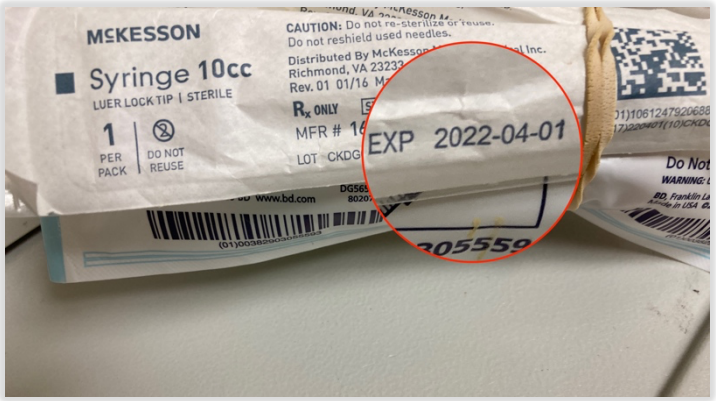

Photo 8. Expired medical supplies stored in the treatment cart dated April 2022 (photographed on 8-9-22).

In addition to the above findings, our compliance inspectors observed the following findings in the clinics or examination rooms when they conducted their on-site inspections:

- At the time of our inspection, the examination room designated staff cabinet was inaccessible. We asked for assistance with the clinic supervisor to access the cabinet. However, the attempt was unsuccessful due to a staff member having taken the key home. In another clinic, the provider denied access to the designated staff cabinet to be tested. As a result, the clinics received a "No" for this test (MIT 5.107).

- A therapist reported that the ergo-bike has been out of order for more than a year, and multiple work orders were submitted without resolution.[25] Clinical staff also reported concerns that several medical supplies were continuously backordered for several months per medical warehouse managers, and the clinic staff were not readily available to provide certain patient care services. Other clinical staff reported concerns regarding clinic staffs' ability to maintain sufficient quantities of medical supplies due to a lack of communication and problems with the reordering process with the medical warehouse managers. We reported the concerns to institutional leadership. The institution reported that the plant operation manager will coordinate with the therapist regarding the ergo-bike. It was also acknowledged that warehouse managers and staff need further training. This activity was being coordinated with headquarters as medical warehouse staff had left the institution, and several staff were new to the position. Warehouse managers reported that the transfer of knowledge from previous managers had not occurred as they had abruptly left the institution. In addition, nursing leadership and warehouse managers conducted ongoing in-person meetings to address the issues that the clinical areas were experiencing (MIT 5.108).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found expired medical supplies (see Photo 9, right, and photo 10, following page); medical supplies stored directly on the floor; storage shelves were dusty (see Photo 11, following page); and the warehouse did not store liquid solutions within the manufacturers' recommended temperature guidelines. We found several solutions had accumulated condensation (see Photo 12, following page).

Photo 9. Expired medical supplies dated August 2021 (photographed on 8-9-22).

[25] An ergo-bike is an ergonomic bike that patients can use for physical therapy.

Photo 10. Expired medical supplies dated July 2022 (photographed on 8-9-22).

Photo 11. Medical supply storage shelves had accumulated dust (photographed on 8-9-22).

Photo 12. IV solutions had accumulated condensation (photographed on 8-9-22).

According to the CEO, the medical warehouse was experiencing issues with ordering and delivering medical supplies, with its staff constantly in communication with CCHCS headquarters to order software training. In addition, they were working on streamlining communication between warehouse and clinics. The CEO also expressed that warehouse managers were new to their positions, and no transfer of knowledge had been provided by the previous managers. The CEO reported that training was being provided biweekly by CCHCS headquarters to medical warehouse managers. In addition, the chief nurse executive (CNE) and warehouse managers were meeting weekly to improve communications between medical warehouse and nursing staff.

Photo 13. Insect found in patient restroom (photographed on 8-10-22).

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected 12 of 37 clinics (MIT 5.101, 32.4%). In 25 clinics, we found one or more of the following deficiencies: cleaning logs were not maintained; floors were unsanitary (in the examination room, beneath the examination room sink, in staff restrooms, and beneath the clinic stretcher); the medical storage cart was unsanitary; insects were found in patient restrooms (see Photo 13, left); and several clinics did not have a system established to replace the insect traps on a regular basis (see Photo 14, below).

Photo 14. Clinics did not have a system established to replace insect traps on a regular basis (photographed on 8-11-22).

Staff in 30 of 37 clinics properly sterilized or disinfected medical equipment (MIT 5.102, 81.1%). In seven clinics, we found one or both of the following deficiencies: staff did not mention disinfecting the examination table as part of their daily start-up protocol, and the nurse did not remove and replace the examination table paper immediately after patient examinations.

We found operating sinks and hand hygiene supplies in the examination rooms in 35 of 37 clinics (MIT 5.103, 94.6%). The patient restrooms in two clinics lacked either antiseptic soap or disposable hand towels.

We observed patient encounters in eight clinics. In five clinics, staff did not wash their hands before or after examining their patients, before applying gloves, and before each subsequent regloving (MIT 5.104, 37.5%).

Health care staff in 35 of 37 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 94.6%). In two clinics, staff did not mention an adequate disinfection process of medical equipment after coming into contact with biohazardous waste.

Physical Infrastructure

At the time of our medical inspection, the institution's administrative team reported no ongoing health care facility improvement program construction projects. The institution's health care management and plant operations manager reported all clinical area infrastructures were in good working order (MIT 5.999).

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	12	25	0	32.4%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	30	7	0	81.1%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	35	2	0	94.6%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	3	5	29	37.5%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	35	2	0	94.6%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	1	36	0	2.7%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	7	30	0	18.9%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	32	2	3	94.1%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	28	9	0	75.7%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	2	17	18	10.5%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 5): **49.3%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.

- Executive leadership should consider performing random spot checks to ensure medical supply storage areas, located inside and outside the clinics, store medical supplies adequately.

- Executive leadership should ensure that random spot checks are performed to ensure clinics, medical storage rooms, and restrooms have been cleaned.

- Nursing leadership should direct each clinic nurse supervisor to review the monthly emergency medical response bag (EMRB) and treatment cart logs to ensure the EMRBs and treatment carts are regularly inventoried and sealed.

Transfers

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(84.3%)

In this indicator, OIG inspectors examined the transfer process for those patients who transferred into the institution as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed whether staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the performance of staff in communicating vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed whether staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

CHCF performed adequately in the transfer process. Compared with Cycle 5, CHCF staff significantly improved on their hospitalization reconciliation process such as performing assessments with vital signs. For patients transferring into CHCF, providers and nurses generally performed timely initial evaluations, and staff ensured medication continuity. For patients transferring out of CHCF, nurses completed the transfer packages, and patients received their medications prior to transfer. However, there was room for improvement on completing the initial health screening form, ensuring hospital medication continuity, and providing preapproved specialty services. Taking all aspects into consideration, we rated this indicator ***adequate.***

Case Review and Compliance Testing Results

We reviewed 51 total events in 23 cases in which patients transferred into or out of the institution or returned from an off-site hospital or emergency room. We identified 22 deficiencies, three of which were significant.[26]

Transfers In

CHCF's transfer-in process was sufficient. Compliance testing showed that the R&R nurses did not always complete the initial health screening form thoroughly (MIT 6.001, 56.0%). However, the nurses always completed the assessment and disposition section of the form (MIT 6.002, 100%). Our clinicians reviewed five

[26] Deficiencies occurred in cases 1, 2, 5, 11, 13, 14, 22, 27–30, 37, 38, and 43. Significant deficiencies occurred in cases 13, 22, and 27.

transfer-in events.[27] The R&R nurses evaluated newly arrived patients and ordered provider appointments within required time frames, without any deficiency patterns noted.

Compliance testing found that staff ensured medication continuity occurred at the time of transfer, and patients received their medications without interruption for patient transfers within the institution (MIT 6.003, 81.3% and MIT 7.005, 88.0%). OIG clinicians noted similar results in case review. In contrast, CHCF did not perform well in medication continuity for patient layovers at the institution for compliance testing (MIT 7.006, 40.0%). Case review did not have any case samples for layover patients.

Compliance testing found that newly arrived patients were often seen by a provider within necessary time frames (MIT 1.002, 88.0%), similar to care review results. However, compliance testing found that only 25.0 percent of preapproved specialty appointments were completed timely (MIT 14.010). Case review clinicians did not identify any missed or delayed preapproved specialty appointments.

Transfers Out

The CHCF transfer-out process was very good. Our clinicians found that R&R nurses performed well. They evaluated patients, completed the transfer packages, frequently ensured an adequate supply of medications, and prepared required documents prior to patients' transferring out of the institution. We identified some deficiencies, but these were not clinically significant.[28] In compliance testing, CHCF performed excellently with ensuring transfer packages included required medications and documents (MIT 6.101, 100%).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high risk for lapses in care quality. These patients typically experienced severe illness or injury. They require more care and place a strain on the institution's resources. In addition, because these patients have complex medical issues, successful health information transfer is necessary for good quality care. Any transfer lapse can result in serious consequences for these patients.

In compliance testing, CHCF performed well in ensuring that patients had timely follow-up appointments after hospitalizations or emergency room visits (MIT 1.007, 87.5%). CHCF performed very well in retrieving and scanning hospital records (MIT 4.003, 93.8%). Providers frequently reviewed the hospital records and reports within five calendar days of discharge (MIT 4.005, 87.5%). Our clinicians reviewed 43 events in which patients returned from a hospitalization or emergency room visit[29] and identified deficiencies with nursing assessments,

[27] Transfer-in events occurred in cases 13, 15, 36, 37, and 38. Deficiencies occurred in cases 36 and 37.

[28] Transfer-out events occurred in cases 39, 40, and 43. Deficiencies occurred in case 43.

[29] Hospitalization events occurred in cases 1–5, 11–14, 22, 26–30, and 42. Deficiencies occurred in cases 1, 2, 5, 11, 13, 14, 22, and 27–30. Significant deficiencies occurred in cases 13, 22, and 27.

interventions, and documentation.[30] However, the deficiencies were not significant and did not impact the overall care of the patient.

One area needed improvement: CHCF performed poorly in medication continuity when patients returned from hospitalization (MIT 7.003, 15.4%). Our clinicians identified four deficiencies related to medication continuity, one of which was significant. Please see the **Medication Management** indicator for further discussion.[31]

Clinician On-Site Inspection

Our clinicians toured the R&R unit and interviewed the day-shift R&R RN, who was knowledgeable about the transfer-in and transfer-out processes. For patients transferring into the institution after business hours, the SEMS provider reconciled all medical medications and the provider-on-call reconciled the mental health medications. When COVID-19 patients arrived at CHCF, they were immediately housed in the designated quarantine unit, and the R&R nurse went to the unit to complete the intake screening process at cell side.

When patients return from hospitalizations, the SEMS nurse and SEMS provider evaluate them. RNs performed a full assessment for patients returning from hospitalizations and focused assessments for patients returning from off-site specialty appointments. The SEMS provider evaluated patient for all hospital returns and reconciled any medication and follow-up appointments. Copies of all hospital return paperwork were placed in the HIM box for scanning, with one copy delivered to the receiving unit and another scanned into an electronic shared folder.

Our clinicians also interviewed the utilization management (UM) RNs to discuss the hospital return reconciliation process for previously approved specialty orders. At the time of our inspection, the institution had three UM nurses. The UM department has designated RNs for hospital admission, discharges, new arrivals, and higher level of care returns.

The staff expressed their belief that morale was positive, and collaboration with custody was cohesive.

[30] Deficiencies identified with nursing assessments, interventions, and documentation occurred in cases 1, 13, and 27–30.

[31] Medication continuity deficiencies occurred in cases 2, 13, 27, and 28.

Compliance Testing Results

Table 12. Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	14	11	0	56.0%
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial health screening form; refer the patient to the TTA if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? (6.002)	25	0	0	100%
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	13	3	9	81.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	2	0	0	100%
Overall percentage (MIT 6): **84.3%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	22	3	0	88.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	14	2	0	87.5%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	15	1	0	93.8%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	14	2	0	87.5%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	2	11	3	15.4%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	22	3	0	88.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	4	6	0	40.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	5	15	0	25.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Nursing leadership should remind and train R&R nurses to completely answer and address required initial health screening questions.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
***Inadequate* (50.8%)**

In this indicator, OIG inspectors evaluated the institution's performance in administering prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

CHCF performed poorly in this indicator. Compared with Cycle 5, our case review clinicians found medication continuity improved in specialty return medication and transfer medication. However, compliance testing showed that CHCF had at least three areas that needed improvement: new medication prescriptions, chronic medication continuity, and layover medications. In sum, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 194 medication events in 31 cases related to medications and found 37 medication deficiencies, seven of which were significant.[32]

New Medication Prescriptions

Compliance testing found that CHCF did not perform well with timely administration and availability of new prescription medications (MIT 7.002, 64.0%). Our clinicians found 10 deficiencies related to new prescription medications, one of which was significant. The following cases provide examples:

- In case 4, the patient received his new prescription medication for an antibiotic eye ointment two days late.
- In case 11, the patient had elevated ammonia levels.[33] The provider prescribed lactulose medication, but the patient received it one day late.

[32] Deficiencies occurred in cases 2–5, 11, 13, 15, 19, 21–30, 36 and 42. Significant deficiencies occurred in cases 4, 13, 19, 24, 27 and 28.

[33] Ammonia is chemical in human body that can be elevated in advanced liver disease. Lactulose medication reduces the ammonia level.

- In case 15, the patient received a newly prescribed keep-on-person (KOP) medication, omeprazole, two days late.[34]

Chronic Medication Continuity

CHCF performed poorly with chronic care medication continuity. Compliance testing found that most patients did not receive their chronic care medications within required time frames (MIT 7.001, 18.2%). Similarly, case review identified 17 deficiencies related to chronic medication continuity, four of which were significant.[35] The following three cases are examples:

- In case 19, the patient's eye drop prescription to treat glaucoma had expired and was not renewed for two months. As a result, the patient did not receive the medication for two months, increasing the risk of worsening glaucoma.

- In case 24, the dialysis patient requested a refill for medication used to reduce the amount of phosphorus levels in the patient's blood. The patient did not receive the medication in the month requested.

- In case 28, the patient did not receive his monthly supply of hypertension medications.

Hospital Discharge Medications

In compliance testing, CHCF performed poorly in ensuring that patients received their medications on return from an off-site hospital or emergency room visit (MIT 7.003, 15.4%). In contrast, our clinicians found most patients received their hospital discharge medication without a lapse in continuity. We reviewed 43 events in which the patient returned from a hospitalization or emergency room visit and identified four deficiencies, including one significant deficiency.[36] The following cases provide examples:

- In case 13, the patient returned from an inpatient hospitalization. The patient's ulcer medication, sucralfate, was ordered two days later, which resulted in eight missed doses.

- In case 28, the patient returned from a community hospital admission. The nurses did not administer the morning doses of prescribed blood pressure medication, steroid inhaler, topical pain cream, and topical steroid cream.

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[34] Keep-on-person" medications are those that a patient can keep and self-administer according to the directions provided. Omeprazole is a medication that reduces stomach acid.

[35] Chronic care medication deficiencies occurred 4, 5, 11, 13, 19, 22–24, and 26–30. Significant deficiencies occurred in cases 4, 13, 19, and 27.

[36] Hospital medication continuity deficiencies occurred in cases 2, 13, 27, and 28. Significant deficiencies occurred in case 13.

Specialized Medical Housing Medications

CHCF had a mixed performance in medication continuity upon patient admissions to the OHU and the CTC. The compliance team found that medications were not consistently administered timely (MIT 13.004, 40.4%). Our clinicians found most medications were administered timely, but there we noted a trend in the lapse in continuity with new medication and chronic care medication, which is discussed in the **Specialized Medical Housing** indicator.

Transfer Medications

Compliance testing found that CHCF performance was good with ensuring that patients who transferred into the institution received their medications timely (MIT 6.003, 81.3%). CHCF also performed well with medication continuity for patients transferring from yard to yard (MIT 7.005, 88.0%). However, patients who were on layover and temporarily housed at CHCF did not always receive their medications within required time frames (MIT 7.006, 40.0%). Analysis of this test result revealed that patients refused their medications, and the nurses did not document the reason for refusal on the medication administration record (MAR). Our clinicians only identified one deficiency related to medication continuity for patients who transferred into the institution.[37] In addition, case review did not find any deficiencies related to patients transferring out of the facility and did not have any case samples of layover patients.

Medication Administration

Compliance found that, mostly, nurses administered tuberculosis (TB) medications within required time frames (MIT 9.001, 85.7%). However, the institution performed poorly with monitoring patients taking TB medications, as required by policy (MIT 9.002, 28.6%). Analysis of this compliance test revealed incomplete weight measurements were made during TB monitoring appointments such as in one case when the nurses did not address the patient's TB symptoms. Our clinicians did not have any case review samples with events related to TB medications.

Our clinicians also found opportunities for improvements with assessments and interventions for monitoring patients on insulin and blood pressure medications.[38] However, these deficiencies did not significantly affect patient care.

Clinician On-Site Inspection

Our clinicians interviewed medication nurses and found that they were knowledgeable about the medication process. Medication nurses reported that they attended all huddles and discussed patient medication refusals, expiring medications, and issues relating to medication orders.

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[37] A transfer-in deficiency occurred in case 36.

[38] Deficiencies occurred in cases 3, 27, and 42.

Our clinicians also met with the leadership team, which included the CNE, the pharmacist in charge (PIC), and nursing supervisors to discuss questions from our case review. The leadership team agreed there were delays in medication continuity and in communications associated with the reconciliation process in the cases we discussed. They reported challenges with inadequate staffing that had negatively affected the ability to provide quality pharmacy services and that more staff were needed to support, maintain, and service the 54 automated drug delivery systems.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in 29 of 35 applicable clinic and medication line locations from the 38 total observed (MIT 7.101, 82.9%). In six locations, we observed one or both of the following deficiencies: medication nurses or the supervising nurse did not describe the narcotic medication discrepancy reporting process, and narcotic medications were not properly and securely stored as required by CCHCS policy.

CHCF appropriately stored and secured nonnarcotic medications in 28 of 38 clinic and medication line locations (MIT 7.102, 73.7%). In 10 locations, we observed one or more of the following deficiencies: the medication storage cabinet was disorganized; the medication area lacked a clearly labeled designated area for medications that were to be returned to the pharmacy; treatment carts were not secured with a red tamper-resistant seal; nurses did not maintain a daily treatment cart check log for the most recent 30 days; and treatment cart logs were missing daily security check entries.

Staff kept medications protected from physical, chemical, and temperature contamination in 23 of the 38 clinic and medication line locations (MIT 7.103, 60.5%). In 15 locations, we found one or more of the following deficiencies: staff did not consistently record room and refrigerator temperatures; staff did not maintain a temperature log; staff did not separate medications from disinfectants; staff did not store oral and topical medications separately; staff did not store several medications within the manufacturer's temperature guidelines; and we found the medication refrigerator was unsanitary.

Staff successfully stored valid, unexpired medications in 24 of the 38 applicable medication line locations (MIT 7.104, 63.2%). In 13 locations, nurses did not label the multiple-use medication per CCHCS policy. In one location, we found an expired medication.

Nurses exercised proper hand hygiene and contamination control protocols in two of seven locations (MIT 7.105, 28.6%). In five locations, some nurses neglected to wash or sanitize their hands before donning gloves or before each subsequent regloving.

Staff in three of seven medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 42.9%). In four locations, we observed one or both of the following deficiencies:

medication nurses did not maintain unissued medication in its original labeled packaging, and medication nurses did not describe the process they followed when reconciling newly received medication and the MAR against the corresponding physician's order.

None of the six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, zero). In six locations, we found one or more of the following deficiencies: medications were not administered to the patients within the time frame; medication nurses did not consistently verify patients' primary and secondary identifications prior to administering medication; medication nurses did not reliably observe patients while they swallowed direct-observation therapy medications; and nurses did not follow insulin protocols properly. Furthermore, medication nurses did not sanitize the glucometer in between patients' uses. During insulin administration, we observed some medication nurses did not properly disinfect the vial's port prior to withdrawing medication. We also observed that medication nurses accepted patient's blood sugar levels that were written on a piece of paper by the patient. The medication nurses did not verify the patient's actual blood sugar level prior to insulin administration.

Pharmacy Protocols

CHCF did not follow general security, organizational, and cleanliness management protocols in its remote pharmacy (MIT 7.108, 50.0%). Pharmacy staff reported an ongoing pest control issue. Staff had notified the plant operations department, and adhesive traps had been set in place. However, no system was in place to monitor and collect the adhesive traps. At the time of our inspection, we found trapped insects had remained in the pharmacy for an undetermined period of time.

Pharmacy staff properly stored nonrefrigerated medications in the main and remote pharmacies (MIT 7.109, 100%).

The institution did not properly store refrigerated or frozen medications in both pharmacies (MIT 7.110, zero). We found one or more of the following deficiencies: unorganized storage of refrigerated medications; an unsanitary refrigerator medication storage bin; pharmacy temperature logs were not maintained using the Medication Storage Temperature Log (CDCR form 7217); and the pharmacy did not have an identifiably designated area for refrigerated medications returned to the pharmacy.

The PIC in one of the two pharmacies did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete several medication-area inspection checklists (CDCR Form 7477). These errors resulted in a score of 50.0 percent in this test (MIT 7.111).

We examined 22 medication error reports. The PIC timely or correctly processed 19 of these 22 reports (MIT 7.112, 86.4%). For one medication error, the PIC did not complete the pharmacy error follow-up review within the required time frame. For the remaining medication errors, the PIC either did not document the

reason why the patient and provider were not notified of the error or did not document that the provider had been notified.

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors also followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At CHCF, the OIG did not find any applicable medication errors (MIT 7.998).

At the time of our inspection, the restricted housing unit was closed. No testing was done for this inspection cycle (MIT 7.999).

Compliance Testing Results

Table 14. Medication Management

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? (7.001) *	4	18	3	18.2%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	16	9	0	64.0%
Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? (7.003) *	2	11	3	15.4%
For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	22	3	0	88.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	4	6	0	40.0%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	29	6	4	82.9%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	28	10	1	73.7%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	23	15	1	60.5%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	24	14	1	63.2%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	2	5	32	28.6%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	3	4	32	42.9%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	0	7	32	0
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	1	1	0	50.0%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	0	2	0	0
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	1	0	50.0%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	19	3	0	86.4%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in restricted housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **50.8%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 15. Other Tests Related to Medication Management

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? (6.003) *	13	3	9	81.3%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	2	0	0	100%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	6	1	0	85.7%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	2	5	0	28.6%
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	19	28	0	40.4%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical and nursing leadership should ensure that medications for new prescriptions, chronic care, hospital discharge, and en-route patients are administered timely and without interruption; leadership should implement remedial training as appropriate.

- Nursing leadership should ensure that nurses document in the patient's MAR the reason for the patient's refusal.

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. If the department designated the institution as high risk for coccidioidomycosis (valley fever), we tested the institution's performance in transferring out patients quickly. The OIG rated this indicator solely according to the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Overall Rating
Adequate

Case Review Rating
(N/A)

Compliance Score
Adequate
(78.2%)

Results Overview

CHCF performed well in administering TB medications as prescribed, screening patients annually for TB, offering patients an influenza vaccine for the most recent influenza season, and offering colorectal cancer screening for all patients ages 45 through 75. The institution faltered in monitoring patients who were taking prescribed TB medications and in offering required immunizations to chronic care patients. These findings are set forth in the table on the next page. Overall, the OIG rated this indicator ***adequate***.

Compliance Testing Results

Table 16. Preventive Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	6	1	0	85.7%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) †	2	5	0	28.6%
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	25	0	0	100%
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 45 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	24	1	0	96.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	10	7	8	58.8%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **78.2%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† In April 2020, after our review but before this report was published, CCHCS reported adding the symptom of *fatigue* into the electronic health record system (EHRS) PowerForm for tuberculosis (TB)-symptom monitoring.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Nursing leadership should consider developing and implementing measures to ensure that nursing staff monitor patients who are prescribed TB medications according to CCHCS policy.

- Medical leadership should determine the causes for challenges to the timely provision of immunizations to chronic care patients.

Nursing Performance

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' performance in making timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing overall nursing performance, our clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and **Specialized Medical Housing**.

Results Overview

CHCF's nursing care was poor overall compared with the performance in Cycle 5. SEMS nurses improved in care documentation in emergency services. However, nurses continued to struggle in such areas as performing complete assessments, activating 9-1-1 for patients with emergent symptoms, and intervening appropriately. In addition, the nurses did not always identify sick call requests with symptomatic complaints and schedule nursing face-to-face appointments timely. After careful consideration, we rated this indicator ***inadequate***.

Case Review Results

Most CHCF patients resided in specialized medical housing units. We reviewed 575 nursing encounters in 59 cases. Among the nursing encounters reviewed, 97 occurred in the outpatient setting. We identified 275 nursing performance deficiencies, 44 of which were significant.[39]

Nursing Assessment and Interventions

A critical component of nursing care is the quality of nursing assessment, which includes both subjective (patient interviews) and objective (observation and examination). CHCF nursing performed poor nursing assessments in both inpatient and outpatient settings. Our clinicians found that nursing staff did not always appropriately triage sick call requests with symptomatic complaints and

[39] Deficiencies occurred in cases 1–6, 9, 11–14, 19, 21–31, 35, 37, 42, 43, 45–48, 51–53, 55, 57–59, 62–64, 66, and 68. Significant deficiencies occurred in cases 1–5, 11–14, 21, 22, 27–30, 42, 59, and 68.

did not co-consult with the provider when medically appropriate. The following cases are examples:

- In case 2, the patient was in the CTC for chronic care illnesses and left-side lower-extremity weakness. Frequently, the nurses performed incomplete assessments, such as not listening to lung, heart, and bowel sounds. Moreover, when the patient complained of dizziness and not feeling well, the nurse did not perform orthostatic vital signs, inquire about the duration of symptoms, assess vital signs, or complete a cardiac, respiratory, skin, or GI assessment. Later in the review period, the nurse evaluated the patient for left-side chest pain. The nurse documented vital signs, contacted the primary care provider, and administered one dose of nitroglycerin. However, the nurse did not listen to lung sounds, bowel sounds, or heart sounds. In addition, the nurse did not perform components of a cardiac assessment including assessing capillary refill, peripheral edema, or perform a complete pain assessment.[40]

- In case 13, the patient with a poor diagnosis of gastroesophageal cancer received care in the OHU for assistance with activities of daily living. This patient had a high risk for aspirating food, or inhaling food and liquids into the lungs. Frequently, nurses did not listen to lung sounds before and after meals to monitor the risk of aspiration. The nurse and the provider performed assessments during rounds. The provider documented that the nurse was concerned over the patient's risk of falling and that the patient was weak and disoriented. However, the nursing assessment done in the morning did not indicate the patient had any symptoms or any neurological deficits.

- In case 28, the patient who was recently diagnosed with esophageal cancer submitted a sick call request for continued weight loss, constant nausea, decreased appetite, and exhaustion. The nurse did not arrange a face-to-face visit with the patient. Instead, the nurse documented on the sick call request that the patient was seen by the primary care provider (PCP) two days prior and was scheduled to see the provider for a chronic care follow-up appointment in 12 days.

- In case 55, the nurse evaluated the patient who submitted a sick call request for complaints of severe right lower-back pain between the pelvis and ribs. The patient reported he had fallen out of bed two weeks prior and sustained a head injury. The nurse did not perform a complete assessment to include palpation of and listening to the abdomen, and assess extremity strength and sensation. In addition, the nurse did not consult with the provider for a same-day evaluation and further plan of care. Instead, the nurse scheduled a provider 14-day follow-up appointment.

[40] Capillary refill is an assessment of blood flow through the peripheral tissues. An abnormal assessment may indicate poor circulation, heart problems, or lung dysfunction.

- In case 59, the nurse evaluated the patient who submitted a sick call request for a chronic, unusual feeling in the middle of the chest that had not been relieved since the previous provider evaluation the month prior and a feeling of obstruction in the throat after eating that resolved after drinking water. The nurse did not immediately consult with the provider for further evaluation of the patient's worsening swallowing symptoms. Instead, the nurse delayed care and ordered a routine 14-day day follow-up with the PCP appointment.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without proper documentation, health care staff can overlook changes in patients' conditions. Nurses demonstrated room for improvement in documenting outpatient care, emergencies, and specialized medical housing.

Nursing Sick Call

Our clinicians reviewed 39 sick call events.[41] We identified that nurses assessed the patients timely, but did not always perform thorough nursing assessments or intervene appropriately. Our clinicians identified 26 deficiencies, five of which were significant. Below, the following cases provide examples:

- In case 21, the nurse evaluated the patient for complaints of increased episodes of rectal bleeding with bowel movements. The nurse incorrectly documented that the sick call request was "asymptomatic chronic medical conditions refer to PCP within 14 days." The nurse should have initiated a face-to-face assessment of the patient's complaint. In addition, the nurse did not address the patient's request for refill of the "bacterial fungus" medication.

- Also in case 21, the nurse reviewed a patient sick call request with requests for a PCP visit after gastrointestinal and audiology specialty follow-ups appointment, and a "left knee current injury." The nurse documented on the slip "all chronic health issues i/p was last seen 5/3/22 issues were addressed. Routine PCP within 14 days." The nurse did not order a next business-day appointment for symptomatic complaint of "left knee current injury."

- In case 28, the nurse evaluated the patient who was recently diagnosed with esophageal cancer who complained of weight loss, constant nausea, decreased appetite, and exhaustion. The nurse documented that the patient had already been seen by the provider and had a follow-up appointment ordered for 14 days later, writing, "This is a chronic problem which plan of care established." The RN

[41] We reviewed sick call request events in cases 21, 24, 25, 28, 31, 45–47, 48, 51, 52, 53, 55, 57–59, and 62–66. Significant deficiencies occurred in cases 21, 28, 59, and 68.

should have arranged a face-to-face visit sooner for this symptomatic patient.

Case Management

Our clinicians reviewed three cases in which patients were evaluated by an RN care manager or LVN care coordinator. Our case review clinicians found the RN case managers performed adequate nursing assessments and interventions. However, our clinicians identified a pattern of nurses not reviewing medication compliance during chronic care appointments in cases 25 and 28.

Wound Care

We reviewed 12 cases in which nursed performed wound care in specialized medical housing.[42] The CHCF wound care team assessed patients timely and performed thorough assessments. However, nurses in specialized medical housing showed room for improvement in assessments and documentation. Our clinicians identified 15 deficiencies in which nurses did not perform wound care, or the assessment of wound care was incomplete. Below, the following cases provide examples:

- In case 1, CTC nurses often did not perform complete daily wound care as ordered. Often, they did not document the color of the wound, assess the condition of surrounding tissue, or whether any drainage was present.

- In case 3, the provider ordered wound care to the left lateral back twice a day. However, CTC nurses did not always perform wound care as ordered.

- In case 27, sometimes, nurses performed incomplete wound care assessments on the patient receiving wound care to the right lower leg.

Emergency Services

We reviewed 42 urgent or emergent events. Nurses responded promptly to emergent events. SEMS nursing staff frequently performed appropriate assessments and interventions. However, our clinicians found first medical responders in specialized medical housing units showed room for improvement in assessments and interventions, which we detail further in the **Emergency Services** indicator.

Hospital Returns

We reviewed 35 events that involved returns from off-site hospitals or emergency rooms. Nursing performed adequately for hospital returns; however, we

[42] Wound care was performed in cases 1, 2, 4, 5, 11, 20, 22, 26, 27, 29, 30, 32, and 42.

identified opportunities for improvement. Please see the **Transfers** indicator for further discussion.

Transfers

We reviewed eight events involving transfer-in and transfer-out processes. For patients arriving to CHCF, the receiving nurses evaluated the patients appropriately, ensured patients received their medications without any interruptions, and initiated provider appointments within required time frames. The transfer-out nurses screened patients adequately and documented pertinent information. Please refer to the **Transfers** indicator for further details.

Specialized Medical Housing

We reviewed 16 CTC cases and 14 OHU cases that included 388 nursing events. We found 200 nursing deficiencies, 30 of which were significant. Nurses performed timely admission assessments, rounding assessments, and level-of-care assessments on patients. However, we identified opportunities for improvement in nursing assessments and documentation. For more specific details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 39 nursing events in 15 cases in which patients returned from specialty services, and found 13 deficiencies, none of which were significant.[43] There was room for improvement in nurses completing vital signs, reviewing recommendations, and performing focused assessments.

- In cases 4, 25, and 28, the patients returned from off-site specialty appointments and nurses who assessed the patients did not perform a complete set of vital signs.

- In cases 11, 21, and 27, the nurses did not document that they reviewed the medications or off-site specialty recommendations.

Medication Management

OIG clinicians reviewed 194 events involving medication management and identified 38 medication deficiencies, eight of which were significant. Both compliance and case reviewers identified opportunities for improvement with medication continuity. Please refer to the **Medication Management** indicator for additional details.

Clinician On-Site Inspection

Our clinician interviewed nursing leadership, SEMS nurse supervisors, and nurses in the OHU, CTC, R&R, outpatient clinics, medication areas, off-site specialty department, public health, and wound care. We attended huddles in the CTC, the OHU, and the outpatient clinics. We observed huddles on E Yard and C

[43] Deficiencies occurred in cases 4, 11, 21, 24, 25, 27, 28, and 29.

Yard that were well organized, and where the staff were knowledgeable and familiar with their patient population. However, in other huddles, the teams did not start timely, and information presented was disorganized and unclear. During our visit, several of the CTC buildings had COVID-19 quarantine patients.

Our clinicians visited the E Clinic, which had four providers, three RNs dedicated for sick call requests, and provider support. There were also two RN care managers. The RN care manager is a new position, active since June 2022. In addition, the medical assistant saw patients to distribute durable medical equipment. LVN duties in the clinic included performing EKG's, providing dressing changes, and performing blood pressure checks. An RN position was also designated as the first responder role for medical emergencies. The first responder role rotated among the five RNs in the clinic. The psychiatric technicians were assigned to respond to the EOP patients in building E1 and called SEMS if needed.

During the E-Clinic huddle, all patient concerns were addressed, and there were no backlogs for any medical lines. The staff reported having issues with obtaining patient medical supplies from the warehouse. Often, they borrowed supplies from other departments including SEMS, obtaining lancets, abdominal pads, and LVN cups for medication administration. RNs stated there were new staff in the warehouse doing the ordering and were told supplies were on back order.

We interviewed SRNs in the clinic, OHU, CTC, and specialty clinic. The SRNs reported they completed monthly audits for 7,362 number of reviews as well as patient care in SEMS, R&R, and the specialized medical housing areas. There was mixed morale among the supervisors. Some supervisors felt supported, while others voiced concerns over not receiving the needed support to run the assigned supervisory locations.

Our clinicians found that the medication nurses in the outpatient clinic had a thorough medication administration process for KOPs and newly ordered medications. The medication nurses explained the process of how newly ordered medications appeared on the task list and how steps were taken to ensure medication request was received by pharmacy. Nurses reviewed the new medication order, ensured delivery from pharmacy, and notified custody staff in the housing units that the patient had KOP medication available to pick up. Nurses reported that the patient had four days to pick up the KOP medication. In addition, the medication nurses also reported they reviewed the daily task list to ensure all blood pressure and wound care appointments were completed prior to the end of their shift if it had not already been completed by the clinic nurses.

The wound care team reported patient wound care was performed daily by the patient care team nurse and weekly by the CHCF wound care team, which would then complete the routine wound measurements and take relevant photographs. Any wounds that needed further evaluation were referred to the CCHCS wound care provider.

Our clinicians discussed the case review questions with nursing leadership. Nursing leadership reported nursing training started in September 2022 for nursing assessments and provided us with the training material that had been

implemented. Starting January 2023, the CNE reported the nursing supervisors would complete a daily audit with nursing to review the documentation. In addition, nursing leadership offered skills training to nurses in December 2022. Nursing leadership also expressed that nursing would be retrained on nursing documentation, policies, and procedures.

Recommendations

- Nursing leadership should ensure that nurses evaluate patients with symptomatic complaints within one business day.
- Nursing leadership should ensure that nurses perform complete, thorough patient assessments and provide appropriate interventions.

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care delivered by the institution's providers: physicians, physician assistants, and nurse practitioners. Our clinicians assessed the institution's providers' performance in evaluating, diagnosing, and managing their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. We assessed provider care through case review only and performed no compliance testing for this indicator.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
(N/A)

Results Overview

Overall, CHCF providers delivered poor care, especially in the CTC and the OHU. Providers did not always thoroughly address patients' complaints, did not take adequate histories, did not perform pertinent examinations, and did not develop appropriate plans to address patients' medical problems. Providers often demonstrated a poor review of the medical record, charted inaccuracies, and did not refer patients as recommended. Finally, some providers copied their previous notes—errors and all—and did not treat the patient in front of them. Considering all aspects, the OIG rated this indicator ***inadequate***.

Case Review Results

OIG clinicians reviewed 457 medical provider encounters and identified 220 deficiencies, 71 of which were significant.[44] In addition, our clinicians examined the quality of care in 30 comprehensive case reviews. Of these 30 cases, we found 21 were ***adequate*** and nine were ***inadequate***.

Decision-Making

OIG clinicians found that providers did not always make good assessments or sound decisions. Deficiencies fell into three categories: not obtaining a proper history based on the complaint, not performing appropriate examinations, and not developing reasonable differentials or plans to address the patient's medical problems.[45] Example are detailed below:

- In case 1, over the course of the review period, the provider did not always obtain pertinent history when the patient complained of various issues, such as shoulder pain, joint pains, back pain, and eye drainage.

[44] Provider deficiencies were in cases 1–5, 11–16, 19–23, 25–30, 32, 33, 35, and 42. Significant provider deficiencies seen were in cases 1, 4, 5, 11–13, 15, 16, 19, 20, 22, 25, 27, 29, 30, 32, 33, and 42.

[45] Decision-making deficiencies were in cases 1, 2, 5, 11, 15, 16, 19–21, 25–27, 29, 30, 32, 33, and 42.

- In case 2, the patient complained about low back pain. The provider did not assess the cause and did not document a treatment plan for the low back pain.

- In case 5, the provider reviewed the hospital report of a patient with tachycardia and did not schedule a provider follow-up for the patient. The next day, a nurse messaged the provider to ask about follow-up. The provider never responded. The patient was sent back out to the hospital seven days later; this was a potentially preventable hospital transfer. Moreover, the nurse notified the provider that the patient, with Parkinson's disease and a recent hospitalization for neck and facial fractures, was deteriorating. The provider did not evaluate the patient.

- In case 11, the patient complained of right-side upper-quadrant abdominal pain and dark urine. A liver disease could have been a cause, but the provider did not order the necessary liver tests until months later. Furthermore, the primary provider did not examine the patient, who had multiple complaints of abdominal pain. This was evidenced by the primary provider having documented normal abdominal examinations, while providers who covered for this primary provider had documented abnormal abdominal examinations.

- In case 12, the patient had a skin pressure ulcer that the primary provider had never acknowledged. The pressure ulcer was noted by a covering provider one day after the primary provider evaluated the patient. This is another example showing how primary providers did not properly examine patients.

- In case 29, the patient was unable to move his right leg and was diagnosed with severe spinal stenosis.[46] The provider saw the patient after the hospitalization, but did not perform an adequate neurologic examination, reassess the patient, determine the patient's neurological baseline, nor assess for potential worsening of symptoms.

- In case 30, the patient's anticoagulation medication was stopped due to bleeding.[47] The provider resumed this medication in error, and the patient was hospitalized weeks later with bleeding. During this case, the patient had low sodium levels detected during multiple hospitalizations. The provider never completely determined the cause of the low sodium. Last, in this case, the nurse notified the provider that the patient had an altered mental status, but the

[46] Spinal stenosis is a medical condition where the spinal column narrows and compresses on the spinal cord. This may cause pain and disability.

[47] An anticoagulant is a type of medication that reduces the risk of blood clots, but increases the risk of bleeding.

provider did not see the patient until an unwitnessed fall occurred five hours later.

- In case 33, the provider evaluated the patient with reported tailbone pain, but did not examine the tailbone itself.

- In case 42, the patient with a history of heart attack, stroke, and diabetes had chest pain. When the provider was notified about the patient's symptom, the provider did not see the patient and did not address the patient's symptom. On several other occasions, this provider also did not respond to messages from the nurses.

Review of Records

Providers did not review medical records carefully. We identified 19 deficiencies.[48] OIG clinicians observed a pattern wherein providers did not review hospital discharge or diagnostic reports completely. Providers sometimes did not follow through with recommendations. Specialized medical housing providers seem to superficially review the information and copied their initial review in their notes for encounters.

- In case 27, the provider endorsed laboratory results that showed a low blood count, but did not address the abnormal laboratory results or document a plan for this abnormality in subsequent progress notes.

- In case 30, the patient's anticoagulant medication was stopped due to bleeding while in the hospital. A provider restarted the medication and was not aware that the patient had to be hospitalized again due to bleeding caused by the anticoagulant. Also in this case, the patient was hospitalized and had one blood culture that was positive for bacteria. Providers did not seem to be aware of this issue as there were no acknowledgments noted in the providers' progress notes. During the review period, the patient had been hospitalized several times and had recommendations to follow up with the urologist because of urinary retention. The provider did not follow through on recommendations for the urology follow-up.

- In case 33, the provider did not accurately review the colonoscopy report that a recommended repeat colonoscopy was needed due to lack of visualization from a poor preparation. The provider documented that the patient did not need a colonoscopy without provided the medical reasoning for the decision.

- In case 42, the provider did not appropriately review critical medical services that occurred. The provider continued to document that the gastroenterologist had recommended no anticoagulation when, in

[48] Deficiencies occurred in cases 5, 20, 25–27, 29, 30, 33, and 42.

fact, the specialist had recommended restarting the patient on an anticoagulant to help prevent a recurrent stroke.

Emergency Care

Providers appropriately managed patients in the SEMS with urgent and emergent conditions. We did not identify any significant deficiencies with SEMS providers during emergent events; however, there were two minor deficiencies that involved the provider-on-call. Both times, the provider did not document a note when contacted by nursing staff during after-hours.[49]

Chronic Care

In most instances, providers appropriately managed the patient's chronic health conditions. Providers performed well in managing chronic medical conditions such as hypertension, diabetes, asthma, hepatitis C infection, and cardiovascular disease. There was one example of poor anticoagulation care as follows:

- In case 15, the provider planned on switching the patient from warfarin, an anticoagulant that requires blood tests for monitoring to maintain appropriate blood thinning, to dabigatran, a direct oral anticoagulant medication that does not require frequent blood tests. The provider stopped the warfarin, but did not order the dabigatran until 17 days after blood tests indicated it was time to start. The pharmacist messaged the provider about a drug-to-drug interaction between the dabigatran and the patient's other medications. The provider finally restarted warfarin four days after that message. As a result, the patient was without anticoagulation medication for 23 days, which increased the patient's risk for a stroke.

Specialty Services

Providers did not always refer patients to specialists for follow-up appointments as recommended by hospitalists and did not document their rationale for not following the recommendations. Examples of significant deficiencies include the following:

- In case 5, the cardiologist recommended a follow-up appointment in three months after changing the patient's heart medication. The provider ordered a six-month follow-up appointment instead.

- In case 22, the provider admitted the patient to the OHU after hospitalization, but did not request the specialty follow-up appointments recommended by the hospitalist.

- In case 30, the neurologist had started a new medication for the patient and recommended a follow-up appointment in two to four weeks, but the provider did not order this. The urologist also

[49] These deficiencies occurred in cases 13 and 30.

recommended a follow-up appointment in one week. However, the provider did not order this recommended appointment either.

Providers' specialty performances are further discussed in the **Specialty Services** indicator.

Incomplete Follow-Through

Providers showed a pattern of developing care plans, but they did not document subsequent plans for following through on them. Following through on case plans is essential to develop rapport with patients. The following are examples of incomplete follow-through:

- In case 4, the patient had a history of COPD with cough and an abnormal diagnostic image.[50] The provider planned on referring the patient to the lung specialist, but did not order the referral until over one month later. This order was automatically discontinued due to the patient being hospitalized, and it was never reconciled, which resulted in the patient not seeing the lung specialist.

- In case 11, the provider planned to order an endoscopy after an ear, nose, and throat (ENT) specialty visit. Although the patient had seen the ENT specialist months earlier, the provider did not order the endoscopy. Also in this case, the provider acknowledged that the patient had a low blood count and was taking iron and folate supplements. The provider planned to recheck the laboratory results once the COVID-19 pandemic had improved. However, the provider did not order the appropriate follow-up laboratory tests to ensure the iron and folate treatment were effective.

Documentation Quality

Providers documented poorly, especially in the specialized medical housing units, which included the CTC and the OHU. Our reviews found that providers were more focused on generating progress notes than address the patients' medical issues. This made it unclear whether providers reviewed readily available information in the chart, whether they attempted to obtain historical information from the patient, whether they examined the patient, and whether they recognized the patient's issues. The qualitative deficiencies can be sorted into at least three categories: inaccurate documentation, legacy charting, and incomplete documentation of medical reasoning.

The first pattern of documentation deficiencies was inaccurate documentation. This was prevalent in the cases we reviewed.[51] In some instances, the errors were not clinically significant. However, these errors were evidence that some

[50] COPD is chronic obstructive lung disease, a medical condition that can cause long term lung problems.

[51] Inaccurate documentation occurred in cases 1, 2, 3, 5, 11, 14, 20, 26, 29, 30, 32, 35, and 42.

providers were not careful with their documentation, and this may have been the result of cloning of notes and a lack of review of the chart.

- On several occasions in case 1, the specialized medical housing provider did not document accurately. He ordered wound care while documenting that the heel ulcer had healed. In other encounters, the provider did not document any ulcers when photos of the ulcers were taken.

- On multiple occasions in case 30, the provider saw the patient who was malnourished and losing weight due to Huntington's disease. The provider kept documenting "well-developed, well-nourished male" when, in fact, the patient had weakness and wasting away due to Huntington's disease.

- On multiple occasions in case 42, the provider documented and continued providing inaccurate information during the review period. These included erroneous specialist recommendations, repeatedly documenting laboratory tests to be ordered that were not ordered, and noting plans that were not followed.

The second pattern seen was cloned elements of documentation.[52] This pattern was also prevalent, and certain cases included multiple instances. The following cases provide examples:

- In case 11, the provider had seen the patient 13 times during the review period, and had cloned the assessment and plan section for the progress note for anemia verbatim.

- In case 26, the provider cloned elements of the physical examination and assessment and plan, which included continued counseling to continue a medication that had not been prescribed for the patient and cloning a statement that the patient's kidney function was improving when it was not.

- In case 29, elements of the history, review of systems, physical examination, and plan were duplicated verbatim multiple times on different progress notes. This calls into question whether the provider evaluated the patient at all.

- In case 42, the provider cloned elements of the assessment and plan, which resulted in inaccurate data about the patient's treatment plans.

The third pattern that we identified was that providers did not always document their thought processes during clinical decision-making and medical reasoning. Although these were minor deficiencies, they occurred 15 times.[53] Another pattern we identified was incomplete assessments and plans. We found 19

[52] We identified cloned elements of progress notes in cases 1, 11, 26, 29, 32, 35, and 42.

[53] These deficiencies occurred with often in cases 2, 5, 11, 29, 30, and 42.

instances in which this occurred.[54] In case 16, the provider did not respond to nursing messages; this occurred five times during the review period.

Provider Continuity

Generally, there was good provider continuity at CHCF. Providers were assigned to specific clinics to ensure continuity of care, and some providers had been on their assigned yards for years. However, we found lapses in continuity due to cross-covering of CTC providers during certain days of the week and after-hours. In three cases, we identified that more than five different providers cared for patients during the review period.[55] In these cases, the quality of care was affected by each provider missing certain aspects of patients' conditions.

- In case 29, the patient was seen by more than seven providers while in the CTC. The lack of continuity combined with poor physical examinations resulted in providers not being aware of the patient's worsening right-leg weakness. The new provider treated the patient's inability to lift the leg as chronic while the neurosurgery referral was delayed. Providers also did not seem to review or be aware of other earlier providers' care decisions. One provider reduced the patient's statin medication due to myalgias.[56] A different provider increased the statin's dosage, only for it to be reduced later due to myalgias.

Clinician On-Site Inspection

The OIG clinicians interviewed medical leadership, providers, and nurses to discuss medical care at CHCF. Medical leadership relayed that at the time of our on-site visit, they were fully staffed with no vacancies. Medical leadership discussed that a challenge was the frequent turnover of custody, mental health leadership and chief effective officers (CEOs), which led to frequent reorganization of priorities and focus. It was reported that the current CEO is the fourth one assigned to this institution in the past one and half years.

During our inspection, each building had a provider assigned during normal operating hours, but the provider could have covered more than one building. SEMS had a provider on the premises from 7 a.m. to 11 p.m. during the weekday and 24 hours on the weekends. The remaining eight hours, during weekdays, were covered by a provider-on-call who took calls by telephone. The providers worked 10 hours a day, four days a week, a schedule which providers felt was a positive aspect.

During 2022, via CDPH waivers, the rounding intervals in the CTC and the OHU were increased, resulting in a decrease in the frequency of provider encounters. This allowed patient loads in the OHU and the CTC to be increased per provider,

[54] These deficiencies occurred in cases 2 and 29.

[55] These occurred in cases 2, 29, and 30.

[56] Statin is a cholesterol reducing medication. A side effect of this medication is myalgia, muscle pain.

from approximately 75 to 100, and 30 to 45, respectively. This change was not implemented during the majority of our review period this cycle.

On the OHU yard, some providers voiced concern about patients verbally assaulting and harassing CHCF staff. Several providers reported feeling personally unsafe; for example, one provider reported that it was not possible to leave the clinic to use the restroom facility without being followed and harassed by incarcerated people. Providers reported that incarcerated people were allowed to stand outside the provider's clinic doors in a threatening manner without facing repercussions or interventions by custody. Providers complained that as a result of this, nursing staff levels on this yard was poor. Usually, registry nurses worked on this yard because regular CHCF nurses felt uncomfortable working here. Providers reported the dilemma to custody and medical leadership, but the providers stated the situation was not corrected.

The majority of providers voiced good morale. Providers told us that they were able to care for their patients appropriately, but they expressed concern about nursing resources. A few providers mentioned that there was no physician support in the specialized medical housing. Their medical assistant was taken away, and they had to rely on nurses to perform clerical duties, such as generating a daily patient visit schedule. They stated it was unfair to the nurses to have to maintain a patient list of those needing to be seen in addition to the regular nursing duties that they needed to perform. Outpatient care teams preferred the previous arrangement in which each primary care team had one provider and one primary care RN. During our inspection, the outpatient clinics had four providers who shared three primary care RNs and two nurse case managers. They preferred the old system.

We discussed the issue of delayed endorsements, and providers stated that these may have been due to the results arriving when they were on their regular day off. Providers stated that the covering providers left nonurgent issues for the primary provider to address when the primary provider returned from the regular day off. The majority of providers voiced support for their CME and reported having good rapport with each other.

Recommendations

- Medical leadership should counsel providers to refrain from copying their previous progress notes without modifying the information to accurately reflect the plan and actions of the medical team.

- Medical leadership should evaluate concerns about personal safety in the OHU units and implement corrective measures.

Specialized Medical Housing

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
***Adequate* (79.7%)**

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We assessed staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. Our clinicians also interpreted relevant compliance results and incorporated them into this indicator. At the time of our inspection, CHCF's specialized medical housing consisted of correctional treatment centers (CTC) and outpatient housing units (OHU).

Results Overview

Overall, CHCF delivered poor care in the CTC and the OHU. Similar to Cycle 5, nursing staff continued to perform incomplete nursing assessments and interventions. Provider performance needed improvement. Although the compliance score was good on the whole, compliance testing showed that patients did not receive medication timely. Factoring both case review results and compliance testing, we rated this indicator ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 14 CTC cases and 12 OHU cases that included 382 provider events and 388 nursing events. Because of the care volume that occurs in specialized medical housing units, each nursing event represents up to two weeks of nursing care. We identified 431 deficiencies, 103 of which were significant.[57]

Provider Performance

Provider performance in the OHU and the CTC was poor due to decision-making, lack of careful review of records, and lapses in documentation quality. The primary care providers who took care of complex patients often documented inaccurate and outdated information due to cloning previous notes. We reviewed 382 provider encounters and identified 196 provider deficiencies.[58] Providers cloned elements of their notes in three cases.[59] However, compliance testing showed that providers timely completed admission histories and physicals (MIT 13.002, 85.1%).

[57] Deficiencies occurred in cases 1–5, 11–20, 22, 23, 26–30, 32, 35, and 42. Significant deficiencies occurred in cases 1–5, 11–20, 27–30, 32, 33, and 42.

[58] Provider deficiencies occurred in cases 1–5, 11–12, 14–16, 19-20, 22, 23, 26, 28, 29, 30, 32, 33, 35, and 42.

[59] Deficiencies occurred in cases 1, 4, and 11.

- In case 1, on multiple occasions, the provider did not obtain a thorough history based on the patient's complaints.

- In case 5, the patient had low blood pressure readings. However, the provider decided not to see the patient due to the COVID-19 outbreak. Subsequently, the patient fell and had multiple facial fractures and a cervical neck fracture. If the provider had addressed the low blood pressure, this may have prevented the falls.

- In case 29, the provider saw the patient with a history of compression of nerve fibers in the lower back that resulted in an inability to move his right lower leg. However, the provider kept documenting the patient had a normal gait.

Nursing Performance

Nurses adequately completed specialized medical housing admission assessments timely (MIT 13.001, 76.6%). Although our clinicians did not identify any missed or delayed admission assessments, we identified a trend with incomplete admission nursing assessments. Examples were seen in the following cases:

- In case 2, the patient was readmitted to the CTC after returning from the hospital for chest pain. The nurse did not listen to lung, heart, and bowel sounds. In addition, the nurse did not assess extremity strength and range of motion.

- In case 22, the patient was admitted to the OHU after discharge from the hospital for septic arthritis of the left shoulder, requiring intravenous antibiotics. Upon admission to the OHU, the nurse did not listen to the patient's heart, lung, and bowel sounds, or assess extremity strength or range of motion.

- In case 30, the patient with Huntington's Disease was first admitted to the OHU for assistance related to the activities of daily living. The patient's health declined from walking independently to later requiring CTC admission for an inability to stand or walk and with urinary symptoms requiring a Foley catheter. Throughout the review period, OHU and CTC nurses often performed incomplete daily nursing assessments. Nurses did not routinely monitor for motor function, assess nutritional status, or monitor the patent's weight.

Our case review clinicians also identified incomplete nursing assessments, delayed interventions, and poor documentation by nursing staff for patients in the CTC and the OHU. Of the 440 deficiencies that we identified in the specialized medical housing cases, 201 were related to the quality of nursing care. Areas of concern include incomplete nursing assessments, nursing assistants not reporting abnormal vital signs to the nurse, lapses in rechecking abnormal vital sign, or not performing pertinent interventions. Examples are seen in the following cases:

- In cases 1, 3, 5, and 11, the CNA or LVN obtained vital signs showing low blood pressure readings, but did not notify the RN for further assessment.

- In cases 1, 5, 11, 26, and 30, our clinicians identified a pattern of incomplete nursing assessments throughout the review period. The nurses frequently did not listen to patients' lung, heart, and bowel sounds.

- In cases 4, 14, and 23, nurses assessed patients who presented with respiratory symptoms. Our clinicians identified a trend in incomplete respiratory nursing assessments including not listening to lung sounds.

- In case 28, the patient was admitted to the OHU after hospitalization for a new diagnosis of esophageal cancer. The patient was started on chemotherapy and radiation, and had an access port for tube feedings. Assessments before and after tube feedings are important in identifying risks related to tube feedings such as aspiration, tube dislodgement, and tube insertion site infections. Frequently, the nurses did not perform the feeding assessments.

- In case 42, the OHU nurse assessed the patient with acute chest pain. The patient had a history of heart disease and a prior stroke. However, the nurse did not perform a thorough cardiac assessment and did not notify the provider of the patient's symptoms.

In compliance testing, the CTC maintained an operational call system to ensure patients have access to care (MIT 13.101, 96.2%).

Medication Administration

CHCF had a mixed performance in medication administration. Compliance testing showed that only 40.4 percent of newly admitted patients received their medications within required time frames (MIT 13.004). Analysis of the compliance data showed medications were not administered timely due to incomplete documentation of medication refusals; KOP medications not administered by the provider's order date and time; medications not delivered by the pharmacy; a prn medication for chest pain was not available for the patient by the order date, and nurse-administered chronic care medications were administered late.[60] In contrast, case review clinicians found most medications were administered timely. We reviewed 151 medication events and identified 18 deficiencies in 13 cases, three were significant.[61]

[60] Prn means as needed. A prn medication as a medication that is taken as needed per the medication instructions.

[61] Deficiencies occurred in cases 3–5, 11, 15, 19, 22, 23, and 26–30.

Clinician On-Site Inspection

CHCF medical facilities included 14 CTC units that provided long-term care, palliative care, and memory care to medically complex patients who required close inpatient observation and medical care. Our clinicians toured a CTC unit which had 30 designated beds, including two negative pressure rooms for respiratory isolation. In addition, the institution also had 12 OHU units that provided services for patients with assistance in daily living activities or short-term medical observation. We visited an OHU unit with 50 beds, including two isolation rooms and four observation rooms.

CTC units had 24-hour nursing staff with SRNs, RNs, LVNs, and CNAs. Each unit had an A and B side with two dedicated providers for the unit. One provider covered the memory care and palliative care units. In the CTC, we were informed nurses and providers performed weekly rounds on all patients. Nursing staff on the unit performed level of care assessments on all patients every 30 days to ensure the patient was placed in the appropriate level of care.

Our teams visited various huddles in the CTC and the OHU. We attended a CTC huddle via conference call. Supervisors, providers, and nurses attended the huddle. The patient care team discussed new arrivals to the unit, specialty returns, medication compliance, and hospital returns. The huddle appeared disorganized with team members providing conflicting information regarding patient care concerning some patients in the unit. On the other hand, we also attended an OHU huddle, which was well-organized. The provider, nursing supervisor, RNs, and LVNs were present and familiar with their patient population including patient medical histories and medical plans of care.

Our clinicians met with nursing leadership to review poor specialized medical housing nursing assessments and documentation. Nursing leadership reported that since September 2022, their staff had also identified deficits in nursing assessment and documentation. Nursing leadership implemented a quality improvement program called the Nursing Strategic Plan. In this program, the SRN II reviews and completes monthly chart audits for nursing quality assessments. The nursing education team continued to email all nursing staff regarding nursing assessments and expectations. After reviewing the OIG on-site questions regarding a lack of thorough assessments, nursing leadership stated that nursing staff had been identified who would receive retraining concerning policies on nursing documentation and systems assessments. In addition, the SRN IIs would be completing daily assessments to include complete patient assessment with the nurses.

Compliance Testing Results

Compliance On-Site Inspection

At the time of our on-site inspection, the MHCB and one OHU clinic had a nonfunctional call light communication system (MIT 13.101, 96.2%). In the MHCB and the OHU, staff maintained patient safety check logs as specified in the institution's local operating procedure in the event the call light system is inoperable (MIT 13.102, 100%).

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *	36	11	0	76.6%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	40	7	0	85.1%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	47	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	19	28	0	40.4%
For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? (13.101) *	25	1	1	96.2%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	2	0	25	100%
			Overall percentage (MIT 13): **79.7%**	

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still have state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Nursing leadership should ensure that CTC and OHU nursing staff perform thorough patient assessments, recognize changes in clinical status, and intervene timely and appropriately for patients with urgent and nonurgent medical conditions.

- Nursing leadership should continue performing nursing performance audits for objective assessments and documentation at regular intervals.

- The institution should consider developing and implementing measures to ensure that staff timely make medications available, administer to patients housed in specialized medical housing, and document in the MAR summaries as described in CCHCS policy and procedures.

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's performance in providing needed specialty care. Our clinicians also examined specialty appointment scheduling, providers' specialty referrals, and medical staff's retrieval, review, and implementation of any specialty recommendations.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
***Inadequate* (62.2%)**

Results Overview

Similar to its performance in Cycle 5, CHCF performed poorly in specialty services for both compliance and case review. Specialty nursing improved and health information performed fairly. However, case review and compliance found that access with specialists could be better. In addition, provider performance for specialty services also needed improvement. In light of these aspects, we rate this indicator as ***inadequate.***

Case Review and Compliance Testing Results

We reviewed 256 events related to specialty services: 198 specialty consultations and procedures, 19 on-site provider specialty encounters, and 39 nursing events. We found 61 deficiencies in this category, 18 of which were significant.[62]

Access to Specialty Services

CHCF performance was mixed in referrals to specialty services. Compliance testing showed a low completion rate of initial high-priority specialty and medium-priority specialty appointments; however, initial routine-priority specialty appointments often occurred timely (MIT 14.001, 40.0%, MIT 14.004, 73.3%, and MIT 14.007, 86.7%). The completion rate of high-priority specialty follow-up appointments fared better, but the completion rates for medium-priority and routine-priority follow-up appointments were low (MIT 14.003, 83.3%, MIT 14.006, 66.7%, and MIT 14.009, 60.0%). Furthermore, CHCF did not provide timely specialty appointments for patients transferring in from another departmental institution with preexisting specialty appointments (MIT 14.010, 25.0%).

Case review clinicians also found that many specialty appointments did not occur within requested time frames. Fifteen scheduling deficiencies were identified, and seven were significant.[63] Deficiencies were found in reconciling outstanding specialty orders upon patients' return from hospitalizations or specialty appointments. Examples of significant access deficiencies include the following:

[62] Deficiencies occurred in cases 1–5, 11, 13, 16, 17, 20–22, and 24–36. Significant deficiencies occurred in cases 1, 3, 5, 20, 22, 26, 29, 30, 32–33, and 35.

[63] Deficiencies occurred in cases 1, 3, 5, 11, 21, 22, 28, 29, 30, 34, and 35. Significant deficiencies occurred in cases 1, 3, 22, 29, and 35.

- In case 3, a referral for a heart imaging study was ordered to occur in 15 to 45 days. The patient received this important heart study 92 days later than the original compliance date.

- In case 29, a cardiology follow-up appointment to evaluate the results of a heart monitor did not occur. The patient was not seen by the cardiologist again until the patient presented with a life-threatening heart arrythmia and systemic infection three months later.

- In case 35, a high-priority interventional radiology referral to treat liver cancer lesions was completed 52 days late.

Provider Performance

Case review found that providers performed poorly in specialty services. Our clinicians found that providers ordered initial specialty services within medically appropriate time frames; however, we identified patterns of late specialty report endorsement, not following specialty recommendations, and specialty follow-up orders not being placed timely. Examples of significant deficiencies include the following:

- In case 16, the cardiologist saw the patient and recommended that amiodarone be discontinued due to an abnormal lung function test.[64] After reviewing the cardiology consultation progress note, the provider did not discontinue the amiodarone and did not document medical reasoning.

- In case 25, nursing co-consulted with the provider for the patient's complaints of right-eye intermittent blurry vision and seeing gray circles, which is a potential eye medical emergency. The nurse documented that the provider requested urgent medical follow-up for the next day, that the provider would review the chart, and the provider would refer the patient to an eye specialist. However, the provider did not address the patient's symptoms, did not refer the patient to an eye specialist, and did not document a progress note explaining medical reasoning.

- In case 30, the hospitalist recommended a urology specialty follow-up appointment to further assess the patient's urinary retention and need for a urethral catheter. However, the provider did not order these recommendations.

- In case 42, the gastroenterology specialist recommended that the patient with a history of stroke be placed on blood thinning medication. The provider reviewed the gastroenterology

[64] Amiodarone is a medication used to treat and prevent serious abnormal heart rhythms. It is used to restore normal heart rhythm and maintain a regular, steady heartbeat. Amiodarone's side effects include damaging effects on the lungs.

recommendations, but did not start the patient on this important medication.

In addition, we noted a pattern of providers incorrectly ordering specialty referrals, leading to referral denials, which in turn led to significant, preventable delays in patient care. The following cases provide examples:

- In case 22, the patient had a high-priority referral for an orthopedic specialty follow-up appointment after hospitalization for surgery of a septic elbow. The patient needed to follow up with the orthopedic specialist; however, the appointment did not occur.

- In case 29, a provider ordered a high-priority referral for a neurosurgery specialist for the patient with a history of severe spinal stenosis and an acute inability to move his right lower extremity. The hospitalist recommended an urgent neurosurgery specialist referral; however, the appointment did not occur until six months later.

Compliance testing found that providers often did not see their patients promptly after high-priority specialty referrals (MIT 1.008, 52.4%). For high-priority referrals, patients need to see the primary care provider within five days of the specialty appointment. Case reviewers did not find any deficiencies in high-priority service provider follow-up, largely due to the SEMS provider seeing the patient in SEMS upon returning from off-site specialty appointments. Usually, the SEMS provider was not the patient's primary care provider.

Provider specialty performance is also discussed in the **Provider Performance** indicator.

Nursing Performance

Case reviewers found that in the 39 nursing specialty events, nurses performed adequately. We identified a pattern of incomplete nursing assessments upon patients' returns from hospitalizations and off-site specialty appointments. However, the patterns we identified did not increase the patients' medical risk or overall care.[65] The following cases provide examples:

- In case 21, the patient had an off-site appointment for a magnetic resonance cholangiopancreatography (MRCP).[66] However, the nurse did not assess the patient on returning from this test.

- In case 24, the patient with end-stage renal disease who was on dialysis, returned to CHCF from an off-site specialty appointment. The specialist evaluated the blood flow of a dialysis access site. The nurse who evaluated the patient on return to CHCF did not document the location of the access site, perform a complete

[65] Deficiencies occurred in cases 4, 5, 11, 21, 24–25, and 27–29.

[66] This is an imaging test used to examine the pancreatic and bile duct systems.

assessment, assess lungs sounds, or take the patient's blood pressure, pulse, or oxygen saturation rate.

This is discussed further in the **Nursing Performance** indicator.

Health Information Management

CHCF performed poorly in the HIM of specialty reports. Compliance testing found specialty reports were scanned within policy time frames 90.0 percent of the time (MIT 4.002); however, providers usually did not review specialty reports timely (MIT 14.008, 66.7%, MIT 14.005, 46.7%, and MIT 14.002, 53.9%).

Case review also found a pattern of specialty reports not being scanned timely and late or missing provider endorsements.[67] Examples of significant deficiencies include the following:

- In case 26, the urology specialty report was scanned late, then not endorsed by a provider.

- In case 35, the patient had an appointment with interventional radiology specialty for follow-up of his cancer treatment. The specialty report was scanned late and not endorsed by the provider.

Clinician On-Site Inspection

OIG case reviewers discussed specialty services with medical leadership, specialty services, HIM leadership, and staff, as well as providers and nurses. CHCF has on-site specialty services including hemodialysis, endoscopy and colonoscopy services, ophthalmology, optometry, physical, occupational therapy, speech therapy, registered dietetics, orthotics services, nephrology, audiology, and neurology. In addition, CCHCS and CHCF providers performed addiction medicine, physical medicine and rehabilitation services, and wound care. Telemedicine services were also available for multiple specialties through CCHCS headquarters' Telemedicine Services.

Leadership reported that in early 2022, CHCF had an outbreak of COVID-19 that affected patients, custody, and medical staff. Only urgent and emergent appointments were being sent to off-site specialists during this period. Leadership stated this contributed to a specialty clinic backlog and delays in specialty care appointments. Radiology had a large backlog that affected this specialty's ability to meet its compliance dates for those services. An on-site specialty provider for endoscopies and colonoscopies canceled all on-site clinics, and staff were required to change those appointments to off-site specialty service appointments. Furthermore, a telemedicine vendor ended its contract with CCHCS, affecting multiple specialties such as nephrology, pulmonology, infectious disease, cardiology, neurology, urology, and gastroenterology. The specialty services staff stated that to increase specialty access during the review period, out-of-region telemedicine services were offered; however, most

[67] Deficiencies occurred in cases 13, 16, 17, 21, 26, 31–33, and 35. Significant deficiencies occurred in cases 26, 32, and 35.

providers elected to defer the visits and continue with the same specialist rather than utilize specialists from different regions in order to maintain continuity of care.

Leadership also reported that after the COVID-outbreak in early 2022, several specialty areas remained difficult to schedule including off-site and telemedicine urology, and pulmonology. All telemedicine urology referrals had been converted to off-site visits unless the provider specified to continue with telemedicine. The optometrist, which had a large number of backlog appointments, added additional clinics to increase access. The colonoscopy and endoscopy backlog appointments were also resolved.

We were told that most patients who were sent to off-site specialists were seen by a SEMS provider upon return and that this appointment constituted the primary care specialty follow-up visit required by CCHCS policy. Our clinicians also interviewed the off-site specialty clinic UM RNs to discuss their process for reconciling orders and follow-up appointments for hospital returns. We interviewed the UM RN in charge of discharge planning and hospital returns. When a patient went out and the UM RN closed the encounter, and SEMS would close the encounter after hours. When a patient was discharged from the hospital, the UM RN notified SEMS and sent out an email to SEMS providers and SEMS staff through Microsoft Outlook, and the UM notes could also be viewed in Cerner. The SEMS RN evaluated the hospital return, and the SEMS provider would reconcile medications and follow-up appointments. The request for service (RFS) specialty orders were reconciled by the UM RN. These nurses had a tracking log for all RFS orders to help identify which pending referrals and appointments were needed when patients were in and out of the hospital. UM RNs and medical records staff had access to records as San Joaquin Hospital and could obtain reports.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? (14.001) *	6	9	0	40.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	6	2	53.9%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	5	1	9	83.3%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	11	4	0	73.3%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	4	2	9	66.7%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	10	5	0	66.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	6	4	5	60.0%
For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames? (14.010) *	5	15	0	25.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	14	5	1	73.7%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	14	6	0	70.0%
				Overall percentage (MIT 14): **62.2%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	11	10	24	52.4%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	27	3	15	90.0%

* The OIG clinicians considered these compliance tests along with their own case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following most specialty services. As a result, we test 1.008 only for high-priority specialty services or when the staff orders PCP or PC RN follow-ups. The OIG continues to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Recommendations

- Medical leadership should ascertain causative factors related to the untimely provision or scheduling of patients' specialty service appointments and implement remedial measures as appropriate.

- Medical leadership should determine the root cause of challenges in patient notification of denials within required time frames and implement remedial measures as appropriate. Specifically, medical leadership should consider provider follow-up time frames of fewer than 30 days to discuss high-priority denials with patients. This may ensure that the rereferral process will be expedited.

Administrative Operations

Overall Rating
Inadequate

Case Review Rating
N/A

Compliance Score
***Inadequate* (72.7%)**

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined whether the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, our inspectors determined whether the institution provided training and job performance reviews for its employees. We checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Results Overview

CHCF's performance was mixed in this indicator. CHCF scored well in some applicable tests; however, others needed improvement. The EMRRC event checklists and other required documents were either incomplete or not reviewed timely. In addition, the institution conducted medical emergency response drills with incomplete documentation. Physician managers did not always complete probationary and annual appraisals in a timely manner. Nurse educators did not ensure that newly hired nurses received the required onboarding training. These findings are set forth in the table on the next page. Overall, we rated this indicator ***inadequate***.

Nonscored Results

At CHCF, the OIG did not have any applicable adverse sentinel events requiring root cause analysis during our inspection period (MIT 15.001).

We obtained CCHCS mortality reporting data. Ten patient deaths occurred during our review period. For all 10 mortality reports, the CCHCS nurse and physician consultant-reviewers did not complete 10 preliminary mortality reports (PMR) within the required time frame. In addition, OIG inspectors found no evidence that the regional and institutional physician and nurse executives received, accepted, or rejected the PMR timely (MIT 15.998).

Compliance Testing Results

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001) *	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	6	0	0	100%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	2	10	0	16.7%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	3	1	0	75.0%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	0	3	0	0
Did the responses to medical grievances address all of the inmates' appealed issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	10	0	0	100%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	9	1	0	90.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	21	12	0	63.6%
Did the providers maintain valid state medical licenses? (15.106)	41	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	6	0	1	100%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	2	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	0	1	0	0
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **72.7%**			

* Effective March 2021, this test was for informational purposes only.

Source: The Office of the Inspector General medical inspection results.

Recommendations

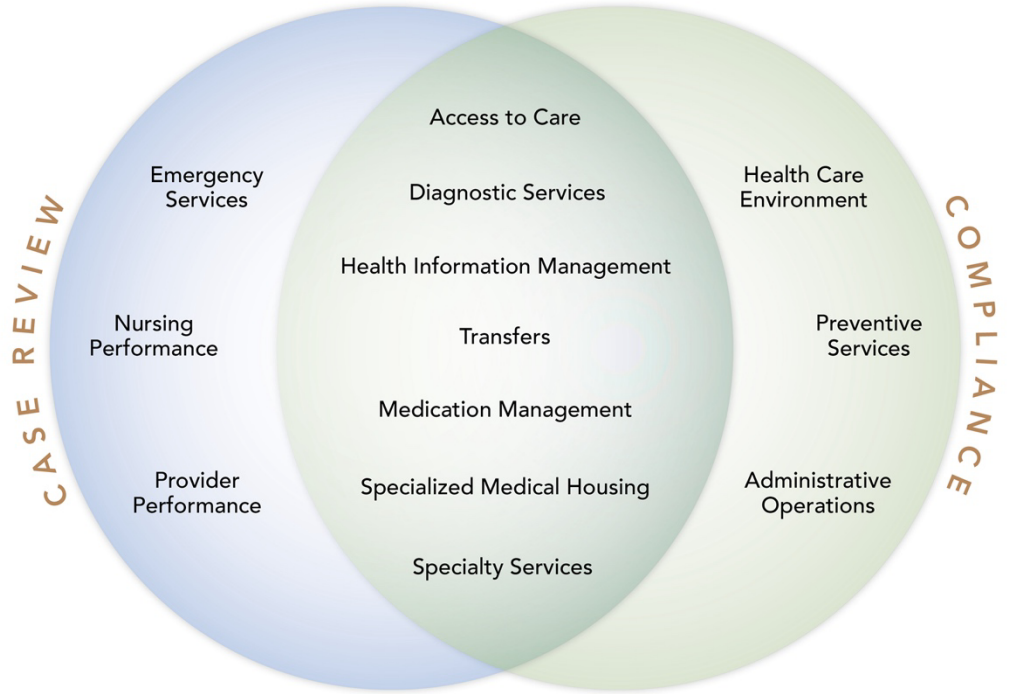
The OIG offers no recommendations for this indicator.

Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We also reviewed professional literature on correctional medical care; reviewed standardized performance measures used by the health care industry; consulted with clinical experts; and met with stakeholders from the court, the receiver's office, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care by combining clinical case reviews of patient files, objective tests of compliance with policies and procedures, and an analysis of outcomes for certain population-based metrics.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for CHCF



Source: The Office of the Inspector General medical inspection results.

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinical analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

Case Review Sampling Methodology

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a predetermined protocol and select samples for clinicians to review. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

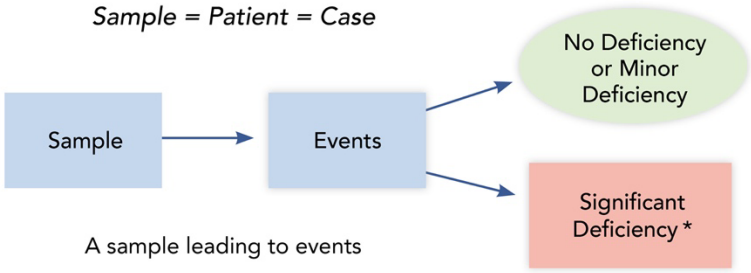
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we refer to as case review ***deficiencies***.

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an ***adverse event***. On the next page, Figure A–2 depicts the possibilities that can lead to these different events.

After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

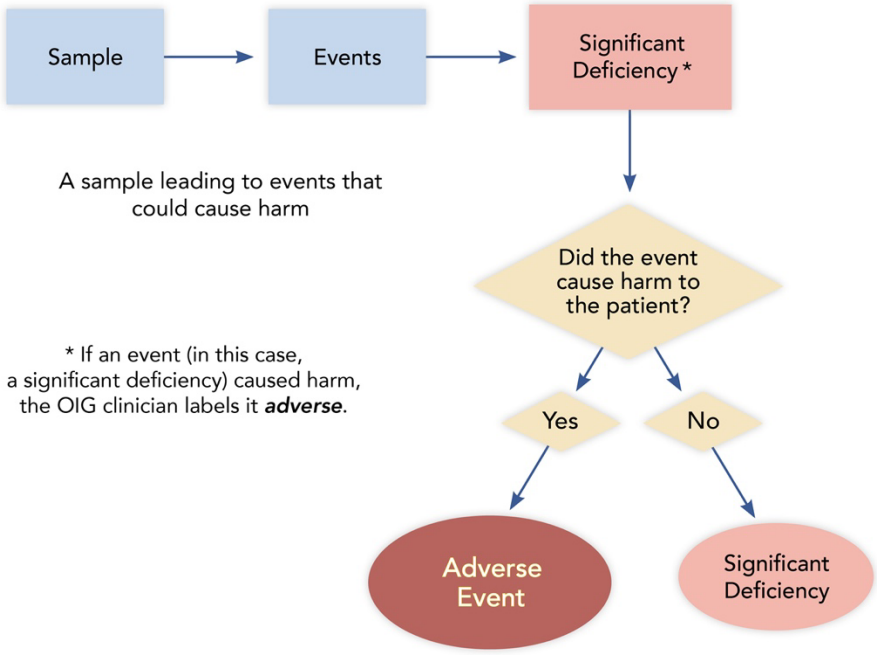
Figure A–2. Case Review Testing

The OIG clinicians examine the chosen samples, performing either a ***comprehensive case review*** or a ***focused case review***, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if errors did occur, then the OIG clinicians determine whether any were ***adverse***.



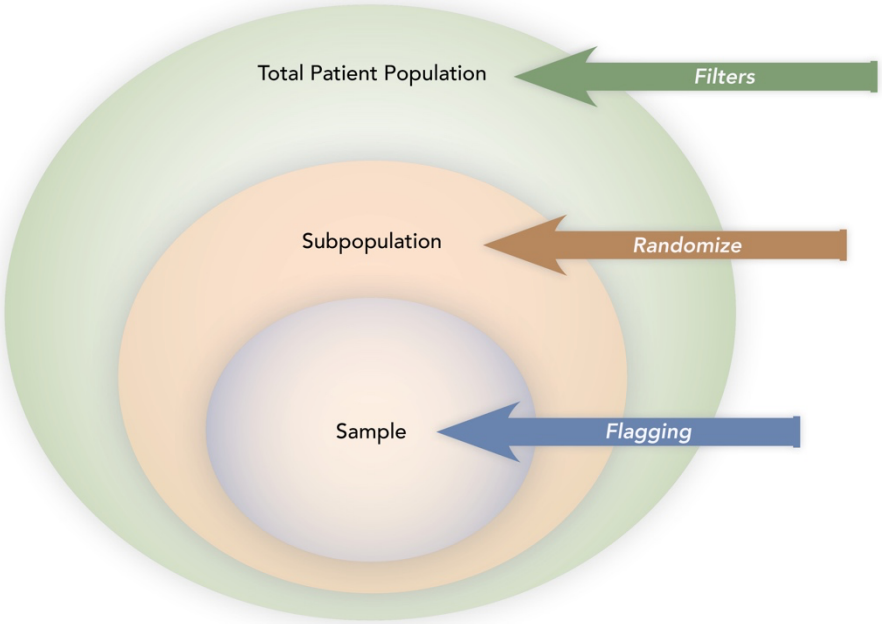
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology



Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing Methodology

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a ***Yes*** or a ***No*** answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all Yes answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B. Case Review Data

Table B–1. CHCF Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	4
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	25
Specialty Services	5
	66

Table B–2. CHCF Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	12
Anticoagulation	9
Arthritis/Degenerative Joint Disease	9
Asthma	9
Cancer	15
Cardiovascular Disease	14
Chronic Kidney Disease	11
Chronic Pain	19
Cirrhosis/End-Stage Liver Disease	8
Coccidioidomycosis	1
COPD	16
COVID-19	4
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	20
Gastroesophageal Reflux Disease	19
Gastrointestinal Bleed	2
Hepatitis C	19
Hyperlipidemia	32
Hypertension	42
Mental Health	27
Migraine Headaches	2
Seizure Disorder	9
Sleep Apnea	8
Substance Abuse	7
Thyroid Disease	8
	323

Table B–3. CHCF Case Review Events by Program

Diagnosis	Total
Diagnostic Services	740
Emergency Care	77
Hospitalization	70
Intrasystem Transfers In	5
Intrasystem Transfers Out	3
Outpatient Care	228
Specialized Medical Housing	1075
Specialty Services	304
	2,502

Table B–4. CHCF Case Review Sample Summary

	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	19
RN Reviews Focused	35
Total Reviews	84
Total Unique Cases	66
Overlapping Reviews (MD & RN)	18

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Appendix C: Compliance Sampling Methodology

California Health Care Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	38	Clinic Appointment List	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	16	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	38	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	45	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	16	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	16	CADDIS Off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	37	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intra-system Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	2	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See Access to Care • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	16	OIG Q: 4.005	• See Health Information Management (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See Reception Center
MIT 7.005	Intra-facility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	10	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	2	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	22	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Restricted Unit KOP Medications	0	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in restricted units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	7	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (45 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	47	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MITs 13.101–102	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	Specialty Services Appointments	• Approval date (3–9 months) • Remove consult to audiology, chemotherapy, dietary, Hep C, HIV, orthotics, gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, physiatry, podiatry, and radiology services • Randomize
MIT 14.010	Specialty Services Arrivals	20	Specialty Service Arrivals	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	19	InterQual	• Review date (3–9 months) • Randomize
		1	SMART Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events	0	Adverse/sentinel events (ASE) report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	33	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	41	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Mortality Reports	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • California Correctional Health Care Services mortality reviews

California Correctional Health Care Services' Response

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September 13, 2023

Amarik Singh, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The Office of the Receiver has reviewed the draft Medical Inspection Report for California Health Care Facility (CHCF) conducted by the Office of the Inspector General (OIG) from December 2021 to May 2022. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 896-6780.

Sincerely,

DocuSigned by:
DeAnna Gouldy
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DeAnna Gouldy
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Directors, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Barbara Barney-Knox, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, CCHCS
Robin Hart, Associate Director, Risk Management Branch, CCHCS
Regional Executives, Region II, CCHCS
Chief Executive Officer, CHCF
Heather Pool, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
David Lavorico, Staff Services Manager I (A), OIG

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

P.O. Box 588500
Elk Grove, CA 95758

Cycle 6

Medical Inspection Report

for

California Health Care Facility

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
September 2023

OIG